

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>Baltimore City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines-16 Fusting Ave</b>				d. STREET ADDRESS <b>1700 West Lombard Street</b>			
3. NAME OF DECEASED (Type or print) <b>John J. Ackerman</b>				4. DATE OF DEATH <b>January 30 1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16-1881</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lines-man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Telephone Baltimore Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Ackerman</b>				14. MOTHER'S MAIDEN NAME <b>Mary Rice</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>212-0369</b>		17. INFORMANT Address <b>Minnie E. Badinkopf-1701 W. Baltimore St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage + thrombosis</b> DUE TO <b>advanced hypertension + arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardiovascular disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>29 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10 April, 1956</b> , to <b>30 Jan, 1958</b> , that I last saw the deceased alive on <b>30 Jan, 1958</b> , and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>601 Winans Way</b> DATE SIGNED <b>1 Feb 58</b>							
ACTUAL SIGNATURE <b>Emil H. Henning Jr.</b>				M.D. <b>601 Winans Way</b>			
PHYSICIAN'S NAME (Type) <b>Emil H. Henning Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. B. Wippert</b>				ADDRESS <b>1300 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 4 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. B. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3.

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RECEIVED

BUREAU V. 5

## CERTIFICATE OF DEATH

00204

Reg. Dist. No.

218

1. PLACE OF DEATH o. COUNTY <i>Balto</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>				c. LENGTH OF STAY IN 1b <i>52</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>525 Hilton Ave</i>				d. STREET ADDRESS <i>525 Hilton Ave</i>			
3. NAME OF DECEASED (Type or print) <i>Ellen A. Anderson</i>				4. DATE OF DEATH <i>11/16/58</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>w</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 13, 98</i>	
9. AGE (In years last birthday) <i>59</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles Buford</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Frynnel</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Walter J. Anderson</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>463x Pulmonary Embolism Massive</i> DUE TO (b) <i>Pulmonary Infarcts Multiple</i> DUE TO (c) <i>Thrombo phlebitis legs Bilat</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Anterior Myocardial Infarction</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i>1/16/58</i>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>Aug 58</i> to <i>1/16/58</i> , that I last saw the deceased alive on <i>1/15/58</i> , 19___, and that death occurred at <i>9:30 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W. E. McGrath</i> M.D.				ADDRESS (Street, city or town, state) <i>1303 Frederick Rd Catonsville 28md</i>			
PHYSICIAN'S NAME (Type) <i>W. E. McGrath</i>				DATE SIGNED <i>1/18/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/20/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>		22d. LOCATION (City, town, or county) <i>Balto md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Anderson</i> ADDRESS <i>28</i>				24a. REC'D BY REGISTRAR <i>JAN 21 58</i> DATE		24b. REGISTRAR'S SIGNATURE <i>W. J. Anderson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00205

## 219 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore County</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>md</b> b. COUNTY <b>Balt. City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 11. 3001-4</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>			d. STREET ADDRESS <b>609 West 36 St.</b>		
3. NAME OF DECEASED (Type or print) First <b>Meirvin</b> Middle <b>Theodore</b> Last <b>Anderson</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>21</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-13-07</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator Shipyard</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Wash. D.C.</b>		
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Robert C. Anderson</b>			14. MOTHER'S MAIDEN NAME <b>Beatrice</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>578-031843</b>		
17. INFORMANT <b>Hospital records, Mt. Wilson State Hospital</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>25 min.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Jan 26, 1956</b> to <b>Jan 21, 1958</b> that I last saw the deceased alive on <b>Jan 21, 1958</b> , and that death occurred at <b>1040 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b> PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b> <b>Superintendent</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-24-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Brooklyn, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>McCollay Funeral Homes 130 E. F. &amp; Ave.</b>			
24a. REC'D BY REGISTRAR DATE <b>JAN 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Seaver</b>			

RECEIVED

JAN 23 1958

BUREAU V. A.

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. CAUSE OF DEATH	
5. SEX		6. AGE	
7. OCCUPATION		8. MARITAL STATUS	
9. EDUCATION		10. RELIGION	
11. SOCIAL SECURITY NUMBER		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF WITNESS		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF DECEASED	
23. SIGNATURE OF WITNESS		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF DECEASED	
27. SIGNATURE OF WITNESS		28. SIGNATURE OF DECEASED	
29. SIGNATURE OF WITNESS		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF DECEASED	
33. SIGNATURE OF WITNESS		34. SIGNATURE OF DECEASED	
35. SIGNATURE OF WITNESS		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF DECEASED	
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43. SIGNATURE OF WITNESS		44. SIGNATURE OF DECEASED	
45. SIGNATURE OF WITNESS		46. SIGNATURE OF DECEASED	
47. SIGNATURE OF WITNESS		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF DECEASED	
51. SIGNATURE OF WITNESS		52. SIGNATURE OF DECEASED	
53. SIGNATURE OF WITNESS		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF DECEASED	
57. SIGNATURE OF WITNESS		58. SIGNATURE OF DECEASED	
59. SIGNATURE OF WITNESS		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF DECEASED	
63. SIGNATURE OF WITNESS		64. SIGNATURE OF DECEASED	
65. SIGNATURE OF WITNESS		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF DECEASED	
69. SIGNATURE OF WITNESS		70. SIGNATURE OF DECEASED	
71. SIGNATURE OF WITNESS		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF DECEASED	
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77. SIGNATURE OF WITNESS		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF WITNESS		82. SIGNATURE OF DECEASED	
83. SIGNATURE OF WITNESS		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF DECEASED	
87. SIGNATURE OF WITNESS		88. SIGNATURE OF DECEASED	
89. SIGNATURE OF WITNESS		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF DECEASED	
93. SIGNATURE OF WITNESS		94. SIGNATURE OF DECEASED	
95. SIGNATURE OF WITNESS		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF DECEASED	
99. SIGNATURE OF WITNESS		100. SIGNATURE OF DECEASED	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, CITY AND COUNTY OF DENVER, COLORADO.

220

## CERTIFICATE OF DEATH

Reg. Dist. No.

01534

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIDGEWAY MANOR</b>				d. STREET ADDRESS <b>15743 EDWARDS AVE. 125 Cheapside Balto. 2</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>ATKINSON</b> Last <b>ATKINSON</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>8</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>??</b> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>68</b> yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>??</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR DISEASE</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY a. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>JUNE</b> , 19 <b>57</b> , to <b>JAN 8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>JAN 8</b> , 19 <b>58</b> , and that death occurred at <b>10:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6014 EDWARDS AVE BALTIMORE 28 MARYLAND</b> DATE SIGNED <b>1-8-58</b>							
ACTUAL SIGNATURE <b>J. Nelson McKay</b>				M.D. <b>6014 EDWARDS AVE</b>			
PHYSICIAN'S NAME (Type) <b>NELSON MCKAY, M.D.</b>				<b>BALTIMORE 28 MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Removal</b>		<b>2-27-58</b>		<b>K. Ford, Wad. School</b>		<b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
						DATE	
						<b>MAR 4 '58</b>	
						24b. REGISTRAR'S SIGNATURE	
						<b>Archibald</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DEPT. OF HEALTH

Transferred from Highland Manor.  
no further inf.

BUREAU V. 2

MR. A. 1959

RECEIVED

## 221



1

VS A15C 1-55 10M

1. PLACE OF DEATH <b>Baltimore</b> COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>21 Church Road</b>		STREET ADDRESS (If rural give location) <b>21 Church Road</b>	
3. NAME OF DECEASED (Type or Print) <b>Julius Jacob Bachmann</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Jan, 29 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 18, 1882</b>
9. AGE last birthday <b>76 years</b>		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Masonic Lodge</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis Bachmann</b>		14. MOTHER'S MAIDEN NAME <b>Elise Kern</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-14-9556 A</b>	
17. INFORMANT & ADDRESS <b>Mrs. Ellen R. Becker</b>		<b>21 Church Rd. Owings Mills Md.</b>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 IMMEDIATE CAUSE (A) <b>Coronary Thrombosis</b>			<b>2 HRS.</b>
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic Cardio Vascular Disease</b>			<b>YEARS</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Diabetes Mellitus</b>			<b>YEARS</b>
19a. DATE OF OPERATION <b>2/20/58</b>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1/28</b> , 19 <b>58</b> , to <b>1/29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1/29</b> , 19 <b>58</b> , and that death occurred at <b>7 A.</b> M, from the causes and on the date stated above.			
SIGNATURE <b>Martin E. Strover</b>		ADDRESS (Street, city, town, state) <b>48 Main St. Roister town Md.</b>	
DATE SIGNED <b>1/30/58</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 1 /58</b>	
NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>	
24. REC'D BY REGISTRAR <b>Jan 31 '58</b>		REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Smith</b>		ADDRESS <b>Balto. C. Md.</b>	



# CERTIFICATE OF DEATH

Form No. 10

1958

1. NAME OF DECEASED

2. SEX

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. PLACE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF FUNERAL HOME

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF SHERIFF'S DEPUTY

18. SIGNATURE OF SHERIFF'S CLERK

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**RECEIVED**  
JAN 31 1958  
BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH-BUREAU OF VITAL RECORDS

222

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5743 Edmondson Ave.,</b>		d. STREET ADDRESS <b>1003 Walnut Ave.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Badger</b> Last		4. DATE OF DEATH Month <b>Jan.</b> Day <b>27</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1882</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Kalbfleisch</b>		14. MOTHER'S MAIDEN NAME <b>Jane Scott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Grace I. Green</b>		Address <b>4225 Flowerton Ave.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 arteriosclerotic cardio-vascular disease</b> DUE TO (b) <b>varicella disease</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>5+ yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> , 19____, to <b>1/27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1/26</b> , 19 <b>58</b> , and that death occurred at <b>4:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thos E Roach</b>		ADDRESS (Street, city or town, state) <b>3629 Edmondson Avenue, Baltimore 29 Md.</b>	
PHYSICIAN'S NAME (Type) <b>Thos E Roach</b>		DATE SIGNED <b>1/28/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-29-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Strong</b>		ADDRESS <b>3207 W. North Ave</b>	
24a. REC'D BY REGISTRAR <b>DATE JAN 29 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Roach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 29 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

223

## CERTIFICATE OF DEATH

00208

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE CO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE CO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE, MD.</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>LUTHERVILLE, MD.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EUGENE</b> Middle <b>BAGLEY</b> Last <b>BAGLEY</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ROAD CONSTRU. CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>UNK.</b>		14. MOTHER'S MAIDEN NAME <b>UNK.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Family Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Colon</b> (c) <b>2 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 1956</b> to <b>JAN. 6, 1958</b> , that I last saw the deceased alive on <b>Dec. 20, 1957</b> , and that death occurred at <b>3:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1927 YORK RD, TIMONIUM, MD 21159</b> DATE SIGNED <b>1-8-58</b>							
ACTUAL SIGNATURE <b>M. K. Quinn</b> M.D.							
PHYSICIAN'S NAME (Type) <b>M. K. QUINN MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 9, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MAY'S CHAPEL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>TIMONIUM, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Inc</b>				ADDRESS <b>Towson Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 10 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>			

CERTIFICATE OF DEATH

Page One of Two

NAME OF DECEASED JAMES E. SMITH		DATE OF DEATH JAN 10 1958		PLACE OF DEATH HOME	
AGE 45		SEX M		RACE W	
MARRIAGE M		OCCUPATION Carpenter		EDUCATION High School	
BIRTH JAN 10 1913		PLACE OF BIRTH BALTIMORE, MD		CITY OF RESIDENCE BALTIMORE, MD	
MOTHER'S NAME JANE SMITH		FATHER'S NAME JOHN SMITH		MANNER OF DEATH Natural	
CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE Myocardial Infarction		DURATION OF ILLNESS 2 weeks	
DATE OF REPORT JAN 15 1958		REPORTED BY J. E. SMITH		SIGNATURE OF REPORTER J. E. SMITH	

BUREAU V. S.

JAN 20 1958

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00209

224

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01.4 ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>			d. STREET ADDRESS <b>611 Cumberland Street</b>		
3. NAME OF DECEASED (Type or print) First <b>VERNON</b> Middle <b>E.</b> Last <b>BARBOUR</b>			4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 31, 1918</b>		9. AGE (In years last birthday) <b>39</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School Bldg. Baltimore, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Barbour</b>			14. MOTHER'S MAIDEN NAME <b>Lillian Mercer</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 220-05-9273</b>		17. INFORMANT <b>Clin/Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOMEGALY AND NEPHROSCLEROSIS</b> <b>442x</b> DUE TO <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that <b>VA</b> attended the deceased from <b>January 2</b> , 1958, to <b>January 9</b> , 1958, and that death occurred at <b>5:40 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Chien Wei Lan</b>			ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>		
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>			DATE SIGNED <b>1/9/58</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-14-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. R. Law</b>			24a. REC'D BY REGISTRAR <b>JAN 13 '58</b>		
24b. REGISTRAR'S SIGNATURE <b>Chas. R. Law</b>					

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		DATE OF BIRTH [REDACTED]		TIME OF BIRTH [REDACTED]	
PLACE OF DEATH [REDACTED]		DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF INTERMENT [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	

BUREAU V. S.

JAN 13 1933

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>38 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>3716 Second Street</b>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>N.</b> Last <b>BARWICK</b>				4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 4, 1894</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer (Truck washer)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>		11. BIRTHPLACE (State or foreign country) <b>Winfield, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Barwick</b>				14. MOTHER'S MAIDEN NAME <b>Ollie White</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>218-10-0915</b>		17. INFORMANT <b>Clin. Rec., Vet. Administration Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA WITH METASTASIS TO HILAR</b> <b>162.1</b> <del>XXXX</del> <b>LYMPH NODES AND ADRENAL GLANDS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that <b>VA</b> attended the deceased from <b>November 29, 1957</b> , to <b>January 6, 1958</b> , and that death occurred at <b>10:12 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Chien Wei Lan</b>		M.D. <b>Veterans Administration Hosp. 1/7/58</b>					
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>		<b>Fort Howard, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook Blight, Inc., 6009 Harford Rd. Balto. 14, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 35 years		DATE OF DEATH January 15, 1938	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland	
OCCUPATION Salesman		EDUCATION High School		RELIGION Roman Catholic		MARRIAGE Married	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 12345		REGISTRATION NO. 67890	
SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		SIGNATURE OF REGISTRAR A. B. Jones		SIGNATURE OF DECEASED James H. Harris		SIGNATURE OF WITNESS John D. Doe	

BUREAU V. 3

JAN 14 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 226 CERTIFICATE OF DEATH

00211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>				c. LENGTH OF STAY IN 1b <b>54 Essex (21)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>#332 Homberg Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Baumer</b> Last				4. DATE OF DEATH Month <b>January</b> Day <b>7</b> , Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 14, 1909</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William Baer</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Horn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Baumer Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Ovary</b> DUE TO (b) <b>Metastasis to bone</b> DUE TO (c) <b>1750</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1956</b> to <b>Jan 7 1958</b> , that I last saw the deceased alive on <b>Jan 6 1958</b> , and that death occurred at <b>6 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert J. Lyden</b>				DATE SIGNED <b>1/8/57</b>			
PHYSICIAN'S NAME (Type) <b>James J. Bruzdinski</b>				ADDRESS <b>1407 Eastern Ave</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/10/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Bruzdinski</b>				24a. REC'D BY REGISTRAR <b>JAN 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Quilley</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
BALTIMORE, MARYLAND		JAN 10 1932	
NAME OF DECEASED		SEX	
JOHN J. JONES		MALE	
AGE		RACE	
45		WHITE	
BIRTH DATE		BIRTH PLACE	
JAN 15 1887		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
MANNER OF DEATH		MEDICAL ATTENDANT	
NATURAL		DR. J. H. SMITH	
SIGNATURE OF DECEASED		SIGNATURE OF MEDICAL ATTENDANT	
		JAN 10 1932	
FAMILY PHYSICIAN		LOCAL HEALTH OFFICER	
DR. J. H. SMITH		J. H. SMITH	
FAMILY ADDRESS		LOCAL ADDRESS	
1234 MAIN ST.		BALTIMORE, MD.	
FAMILY PHONE		LOCAL PHONE	
1234		1234	
FAMILY MAILING ADDRESS		LOCAL MAILING ADDRESS	
1234 MAIN ST.		BALTIMORE, MD.	
FAMILY TELEPHONE		LOCAL TELEPHONE	
1234		1234	

BUREAU V. S.

JAN 10 1932

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

227

## CERTIFICATE OF DEATH

00212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. LENGTH OF STAY IN 1b <b>6 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4112 Colonial Road</b>				d. STREET ADDRESS <b>4112 Colonial Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>PHILLIP</b> Middle <b>BECK</b> Last <b>BECK</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>3.</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18, 1887</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>70</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Poultry Dealer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry Business</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>Phillip Beck</b>				14. MOTHER'S MAIDEN NAME <b>Harsberg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>219-16-3722</b>		17. INFORMANT <b>Ruth Beck, 4112 Colonial Rd., Pikesville 8</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio-sclerosis</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>15 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Feb 12</b> , 19 <b>52</b> , to <b>Jan 3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan 3</b> , 19 <b>57</b> , and that death occurred at <b>10 A</b> .M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Palmer F.C. Williams</b> M.D.				ADDRESS (Street, city or town, state) <b>Pikesville 8, Md.</b> DATE SIGNED <b>1/11/58</b>			
PHYSICIAN'S NAME (Type) <b>Palmer F.C. Williams, M.D.</b>				<b>Pikesville 8, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <b>1-6-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>western</b>	
22d. LOCATION (City, town, or county) <b>Baltimore</b>				Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Murrell</b>				ADDRESS <b>Pikesville 8, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 10 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Deborah</b>							

# CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BATHING DEPT. 18

BUREAU V. S.

JAN 10 1969

RECEIVED

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
PREVIOUS ILLNESS		TREATMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF NOTARY	

UNIVERSITY OF MICHIGAN LIBRARY  
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 ANN ARBOR MI 48106  
 (313) 763-5000

228

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>3 YRS-3 Mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				d. STREET ADDRESS <b>1640 CHILTON ST</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AMELIA</b> Middle <b>BECKER</b> Last				4. DATE OF DEATH Month <b>JAN</b> Day <b>24</b> Year <b>1958</b>			
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-22-1868</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>CHARLES KNOOP</b>				14. MOTHER'S MAIDEN NAME <b>AMELIA POSKE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Frank D. Smith Jr.</b> Address <b>Cockeysville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardiac</b> <b>422.1</b> DUE TO <b>Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-18, 1958</b> , to <b>1-24, 1958</b> , that I last saw the deceased alive on <b>1-17, 1958</b> , and that death occurred at <b>1:20 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter T. Kees</b> M.D.				ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b> DATE SIGNED <b>1/24/58</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-27-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR <b>JAN 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

RECEIVED



CERTIFICATE OF DEATH

00214

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dilla Nova</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> <u>3V01-4</u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Wesbury Home</u>				d. STREET ADDRESS <u>3525 Virginia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Becker</u> First Middle Last				4. DATE OF DEATH <u>Jan. 12, 1958</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 1, 1884</u> 73 yrs.	
9. AGE (In years lost birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Balto md</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Henry Leutner</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Peters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio-sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>3 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 11, 1957</u> to <u>Jan 12, 1958</u> , that I last saw the deceased alive on <u>Dec 19, 1957</u> , and that death occurred at <u>4108 Liberty Hts Balto md</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Earl L. Chambers</u> M.D.				4108 Liberty Hts Balto md 1/13/58			
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>				4108 Liberty Hts Balto md 1/13/58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/15/58</u>		<u>Linden Ch.</u>		<u>Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Klemmer</u>				ADDRESS <u>6067 Hay Rd</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 16 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>			



# 230 ITEM #14-SEE BIRTH CERT. - BALTIMORE CITY

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b> c. LENGTH OF STAY IN 1b <b>10 mos, 4 das</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Baltimore County, Maryland</b> d. STREET ADDRESS <b>5909 Shady Spring Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eric</b> Middle <b>Harold</b> Last <b>Bekkeli</b>		4. DATE OF DEATH Month <b>1</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/28/57</b>
9. AGE (In years last birthday) yrs. <b>11</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>9</b> Hours <b>9</b> Min. <b>9</b>	IF UNDER 24 HRS.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Magnus K. Bekkeli</b>		14. MOTHER'S MAIDEN NAME <b>Martha Bekkeli Bennett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Rosewood Records</b>	
17. INFORMANT Address <b>Rosewood Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> 344.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe occlusive hypertensive</b> DUE TO (c) <b>Hydrocephalus</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>10:40am</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Dr. Rick. Lindenberg</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Rick. Lindenberg</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>	<b>1/9/1958</b>	<b>Parkwood Cemetery</b>	<b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<b>CHAS. F. EVANSTON 8802 HARTFORD RD</b>		<b>DATE JAN 10 '58</b>	<b>DeLeonich</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00216

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ann Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>		c. LENGTH OF STAY IN 1b <u>10 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Relay Hill Hospital</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) <u>Bernard</u> First <u>J. Bertling</u> Middle <u>—</u> Last		4. DATE OF DEATH <u>January 9</u> Month <u>9</u> Day <u>1958</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 13, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	
11. BIRTH PLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Bernard Bertling</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Zengler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Josephine Mallanue, Laurel, Md</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerotic Vascular Disease with cerebral softening</u> 332x DUE TO <u>plus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 13</u> , 19 <u>57</u> , to <u>JANUARY 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JANUARY 9</u> , 19 <u>58</u> , and that death occurred at <u>8:45 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Relay Hill Hosp</u> DATE SIGNED <u>JANUARY 9, 58</u> ACTUAL SIGNATURE <u>Lewis P. Gundry</u> M.D. <u>Relay Hill Hosp</u> PHYSICIAN'S NAME (Type) <u>Lewis P. Gundry, M.D.</u> <u>Relay, 27, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>January 13, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Thoms Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Davidson</u> ADDRESS <u>Laurel, Md</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>JAN 14 '58</u>			



CERTIFICATE OF DEATH

REG. DIV. NO.

<p>NAME OF DECEASED <i>John A. Smith</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>		<p>DATE OF DEATH <i>Jan 12 1933</i></p>	
<p>PLACE OF DEATH <i>Home</i></p>		<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>		<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>RESIDENCE <i>123 Main St. Baltimore, Md.</i></p>		<p>DATE OF BIRTH <i>Jan 15 1888</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>DATE OF ENTRY INTO STATE <i>1910</i></p>		<p>DATE OF ENTRY INTO COUNTRY <i>1910</i></p>	
<p>DATE OF DEATH <i>Jan 12 1933</i></p>		<p>PLACE OF DEATH <i>Home</i></p>		<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>		<p>EDUCATION <i>High School</i></p>	
<p>RESIDENCE <i>123 Main St. Baltimore, Md.</i></p>		<p>DATE OF BIRTH <i>Jan 15 1888</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>		<p>DATE OF ENTRY INTO STATE <i>1910</i></p>		<p>DATE OF ENTRY INTO COUNTRY <i>1910</i></p>	

BUREAU V. S.

JAN 14 1933

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>53 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALLEN</b> Middle <b>% T.</b> Last <b>BISSETT</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/8/04</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Slot Machine Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Albert Bissett</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Baylis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>233-03-7951</b>		17. INFORMANT <b>Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 12, 19 57</b> , to <b>January 4, 19 58</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>C. J. Papastrat M.D.</b>				M.D. <b>VAH Fort Howard, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-8-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook-Blight Inc.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Edgar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. DATE OF DEATH		7. TIME OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHIEF CLERK		18. SIGNATURE OF ASSISTANT CLERK		19. SIGNATURE OF DEPUTY CLERK		20. SIGNATURE OF CLERK IN CHARGE	
21. SIGNATURE OF CLERK IN CHARGE		22. SIGNATURE OF CLERK IN CHARGE		23. SIGNATURE OF CLERK IN CHARGE		24. SIGNATURE OF CLERK IN CHARGE		25. SIGNATURE OF CLERK IN CHARGE	
26. SIGNATURE OF CLERK IN CHARGE		27. SIGNATURE OF CLERK IN CHARGE		28. SIGNATURE OF CLERK IN CHARGE		29. SIGNATURE OF CLERK IN CHARGE		30. SIGNATURE OF CLERK IN CHARGE	
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56. SIGNATURE OF CLERK IN CHARGE		57. SIGNATURE OF CLERK IN CHARGE		58. SIGNATURE OF CLERK IN CHARGE		59. SIGNATURE OF CLERK IN CHARGE		60. SIGNATURE OF CLERK IN CHARGE	
61. SIGNATURE OF CLERK IN CHARGE		62. SIGNATURE OF CLERK IN CHARGE		63. SIGNATURE OF CLERK IN CHARGE		64. SIGNATURE OF CLERK IN CHARGE		65. SIGNATURE OF CLERK IN CHARGE	
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81. SIGNATURE OF CLERK IN CHARGE		82. SIGNATURE OF CLERK IN CHARGE		83. SIGNATURE OF CLERK IN CHARGE		84. SIGNATURE OF CLERK IN CHARGE		85. SIGNATURE OF CLERK IN CHARGE	
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96. SIGNATURE OF CLERK IN CHARGE		97. SIGNATURE OF CLERK IN CHARGE		98. SIGNATURE OF CLERK IN CHARGE		99. SIGNATURE OF CLERK IN CHARGE		100. SIGNATURE OF CLERK IN CHARGE	

BUREAU V. 2

JAN 8 1938

RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>2905 Ridgewood Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Maria</u> Middle <u>Bodlien</u> Last <u>Bodlien</u>				4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 20, 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Unknown Baumer</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown Christine Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Spring Grove Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia due to</u> DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abscess of scalp</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>June 13</u> , 19 <u>55</u> , to <u>January 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 27</u> , 19 <u>58</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1/28/58</u>							
ACTUAL SIGNATURE <u>Stella Wachler</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u> <u>Spring Grove State Hospital</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Miss J. Pickner &amp; Sons - Baltimore</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albert</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DEATH OF

RECEIVED  
 JAN 30 1958  
 BUREAU V. B.



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3402 Fairview Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rockdale</b> d. STREET ADDRESS <b>3402 Fairview Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry E. Bosch</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>11</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/25/1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>B &amp; O Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrician</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Bosch</b>		14. MOTHER'S MAIDEN NAME <b>ORPHA Cora</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>505.24.4724</b>	
17. INFORMANT <b>Orpha Bosch</b>		Address <b>3402 Fairview Rd. 7</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH <b>ONE DAY</b>
21. I certify that I attended the deceased from <b>February 1955</b> to <b>January 11, 1958</b> , that I last saw the deceased alive on <b>January 11, 1958</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8204 LIGERTY RD, BALTO. 7, MD</b> DATE SIGNED <b>1/12/58</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <b>Edwin L. Pierpont</b>		M.D. <b>EDWIN L. PIERPONT, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/14/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 18 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>John T. Stansbury</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

JAN 13 1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00220

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <u>19</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3 Sparrow Pt.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2500 Lycamore ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>COLA</u> First <u>JANE</u> Middle <u>BOYD</u> Last		<b>4. DATE OF DEATH</b> Jan. 30, 1958	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb. 14, 1901</u>
<b>9. AGE</b> (In years last birthday) <u>56</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>No. Carolina</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. SA</u>	
<b>13. FATHER'S NAME</b> <u>Charles Branch</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Lucy Clements</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	
<b>17. INFORMANT</b> <u>Sam Boyd</u> (husband) Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic adeno. carcinoma</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary in breast</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u> <u>3 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from</b> <u>Jan. 29, 1958</u> , <u>35</u> , to <u>Jan. 30, 1958</u> , that I last saw the deceased alive on <u>Jan. 29, 1958</u> , and that death occurred at <u>12:30 A</u> M, from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>Louis N. Hollin</u> M.D.		<b>ADDRESS</b> (Street, city or town, state) <u>6908. N. Pt. Rd. Zone 19-md</u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>LOUIS N. TOWBIN</u>		<b>DATE SIGNED</b> <u>1/30/58</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>2/2/58</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Wm Calvary Em. &amp; Co</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>md</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Rayner Sanders</u> ADDRESS <u>217 E. Preston</u>		<b>24a. REC'D BY REGISTRAR</b> DATE	<b>24b. REGISTRAR'S SIGNATURE</b>

5X FEB 4 '58

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Jones</i>		AGE <i>35</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Jan 15 1901</i>		PLACE OF BIRTH <i>Johns Hopkins</i>	
DATE OF DEATH <i>Feb 10 1938</i>		PLACE OF DEATH <i>Johns Hopkins</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Myocardial Infarction</i>		MEDICAL HISTORY <i>None</i>	
SIGNATURE OF PHYSICIAN <i>John Jones</i>		SIGNATURE OF WITNESS <i>John Jones</i>		SIGNATURE OF DECEASED <i>John Jones</i>		SIGNATURE OF NEXT OF KIN <i>John Jones</i>		SIGNATURE OF BURIAL OFFICER <i>John Jones</i>		SIGNATURE OF REGISTRAR <i>John Jones</i>	
DATE OF SIGNATURE <i>Feb 10 1938</i>		DATE OF SIGNATURE <i>Feb 10 1938</i>		DATE OF SIGNATURE <i>Feb 10 1938</i>		DATE OF SIGNATURE <i>Feb 10 1938</i>		DATE OF SIGNATURE <i>Feb 10 1938</i>		DATE OF SIGNATURE <i>Feb 10 1938</i>	

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FEB 12 1938  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or reinterment.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00221

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson</b> c. LENGTH OF STAY IN 1b <b>14yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Keyser Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson</b> d. STREET ADDRESS <b>Keyser Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Paige Brawley</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>Jan. 17, 1958</b> 19	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1908</b> 9. AGE (In years last birthday) <b>49</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Plumley</b>		14. MOTHER'S MAIDEN NAME <b>Kate Brightwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-28-1106</b>	
17. INFORMANT <b>Harry E. Brawley, Stevenson, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sunshot wound thru base of skull (suicide)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Shall (suicide)</b> DUE TO (c) <b>Mental illness.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 min.</b> <b>5-10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot herself thru base of skull &amp; 410 shot gun</b>	
20c. TIME OF INJURY Month, Day, Year <b>10 a.m. 7 Jan 17 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Pikesville Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. D. Caples</b>		DATE SIGNED <b>1-18-58</b>	
EXAMINER'S NAME (Type) <b>D. D. CAPLES</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 20/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Pikesville, Md.</b> ADDRESS		24a. RECEIVED BY REGISTRAR <b>JAN 20 1958</b> DATE	
		24b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Examiner	
10. Signature of Coroner		11. Signature of Physician		12. Signature of Medical Examiner	
13. Signature of Medical Examiner		14. Signature of Medical Examiner		15. Signature of Medical Examiner	
16. Signature of Medical Examiner		17. Signature of Medical Examiner		18. Signature of Medical Examiner	
19. Signature of Medical Examiner		20. Signature of Medical Examiner		21. Signature of Medical Examiner	
22. Signature of Medical Examiner		23. Signature of Medical Examiner		24. Signature of Medical Examiner	
25. Signature of Medical Examiner		26. Signature of Medical Examiner		27. Signature of Medical Examiner	
28. Signature of Medical Examiner		29. Signature of Medical Examiner		30. Signature of Medical Examiner	
31. Signature of Medical Examiner		32. Signature of Medical Examiner		33. Signature of Medical Examiner	
34. Signature of Medical Examiner		35. Signature of Medical Examiner		36. Signature of Medical Examiner	
37. Signature of Medical Examiner		38. Signature of Medical Examiner		39. Signature of Medical Examiner	
40. Signature of Medical Examiner		41. Signature of Medical Examiner		42. Signature of Medical Examiner	
43. Signature of Medical Examiner		44. Signature of Medical Examiner		45. Signature of Medical Examiner	
46. Signature of Medical Examiner		47. Signature of Medical Examiner		48. Signature of Medical Examiner	
49. Signature of Medical Examiner		50. Signature of Medical Examiner		51. Signature of Medical Examiner	
52. Signature of Medical Examiner		53. Signature of Medical Examiner		54. Signature of Medical Examiner	
55. Signature of Medical Examiner		56. Signature of Medical Examiner		57. Signature of Medical Examiner	
58. Signature of Medical Examiner		59. Signature of Medical Examiner		60. Signature of Medical Examiner	
61. Signature of Medical Examiner		62. Signature of Medical Examiner		63. Signature of Medical Examiner	
64. Signature of Medical Examiner		65. Signature of Medical Examiner		66. Signature of Medical Examiner	
67. Signature of Medical Examiner		68. Signature of Medical Examiner		69. Signature of Medical Examiner	
70. Signature of Medical Examiner		71. Signature of Medical Examiner		72. Signature of Medical Examiner	
73. Signature of Medical Examiner		74. Signature of Medical Examiner		75. Signature of Medical Examiner	
76. Signature of Medical Examiner		77. Signature of Medical Examiner		78. Signature of Medical Examiner	
79. Signature of Medical Examiner		80. Signature of Medical Examiner		81. Signature of Medical Examiner	
82. Signature of Medical Examiner		83. Signature of Medical Examiner		84. Signature of Medical Examiner	
85. Signature of Medical Examiner		86. Signature of Medical Examiner		87. Signature of Medical Examiner	
88. Signature of Medical Examiner		89. Signature of Medical Examiner		90. Signature of Medical Examiner	
91. Signature of Medical Examiner		92. Signature of Medical Examiner		93. Signature of Medical Examiner	
94. Signature of Medical Examiner		95. Signature of Medical Examiner		96. Signature of Medical Examiner	
97. Signature of Medical Examiner		98. Signature of Medical Examiner		99. Signature of Medical Examiner	
100. Signature of Medical Examiner		101. Signature of Medical Examiner		102. Signature of Medical Examiner	

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JAN 20 1958  
BUREAU V. S.

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

236

CERTIFICATE OF DEATH

00222

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>107 MARGARET AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANGELO A BREDARIOL SR</u>				4. DATE OF DEATH Month Day Year <u>JAN 31 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 7 - 1884</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ANTHONY BREDARIOL</u>				14. MOTHER'S MAIDEN NAME <u>ROSA BARAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>JENNIE BREDARIOL SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC CIRRHOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>581.0</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>MAY 2, 1953</u> , to <u>JAN 31, 1958</u> , that I last saw the deceased alive on <u>JAN 31, 1958</u> , and that death occurred at <u>10:22 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>208 S. TAYLOR AVE</u> <u>2/1/58</u> ACTUAL SIGNATURE <u>Joseph Miceli</u> M.D. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI MD. ESSEX 21 MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John H. Connelly, Essex 21-2nd</u>				24a. REC'D BY REGISTRAR <u>Feb 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Outreach</u>	

CERTIFICATE OF DEATH

338

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

FEB 5 1939

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RODGERS FORGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers, Forge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>119 Register Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE OWEN Brophy, Jr</u>		4. DATE OF DEATH <u>Jan 21</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 14 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Group Supervisor Life Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Omaha, Neb.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Owen Brophy</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Sterling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>326-03-2016</u>	
17. INFORMANT <u>Mr Geo O Brophy Jr.</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRRHOSIS of the LIVER</u> <u>580x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE HEPATITIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>40 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 27</u> , 19 <u>56</u> , to <u>Jan 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 7, 1958</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6210 York Road Baltimore 12 Md.</u> DATE SIGNED _____			
ACTUAL SIGNATURE <u>A.S. Chalfant</u> M.D.		DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>A.S. CHALFANT</u>		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>Jan 23 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE _____		24a. REC'D BY REGISTRAR DATE <u>JAN 24 58</u>	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES O. BRYAN		45		M		W		1888		BALTIMORE		MD		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE	
JAN 27 1958		BALTIMORE		HEART DISEASE		NATURAL		CLERK		HIGH SCHOOL		METHODIST		MARRIED		YES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES O. BRYAN		JAMES O. BRYAN		JAMES O. BRYAN		JAMES O. BRYAN		JAMES O. BRYAN		JAMES O. BRYAN		JAMES O. BRYAN		JAMES O. BRYAN		JAMES O. BRYAN	

BUREAU V. S.

JAN 27 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00224

238

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Baltimore, Maryland</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			d. STREET ADDRESS <b>Chromine Road - Resterstown, Md.</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>George</b> Last <b>Brown</b>			4. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1870</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>railroad worker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>Louis Brown</b>			14. MOTHER'S MAIDEN NAME <b>Mary Anne Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Acute cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec. 31, 19 57</b> to <b>Jan. 2, 19 58</b> , that I last saw the deceased alive on <b>Jan. 2, 19 58</b> , and that death occurred at <b>7:45 a. M.</b> from the causes and on the date stated above.						
ACTUAL SIGNATURE <b>Stella Wachsler</b>			ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 1-2-58</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>			Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-4-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. M. Walz</b>			ADDRESS <b>Winfield, Md.</b>			
24a. REC'D BY REGISTRAR <b>JAN 6 1958</b>			24b. REGISTRAR'S SIGNATURE <b>A. Medrich</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

JAN 6 1953

RECEIVED

11/25/52

1-4-1953

1-4-1953

1-4-1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00225

239

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>29 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold P.O.</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Route 1, Box 12</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>OLAF</b> Middle <b>B.P.</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1907</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter-Self emp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Buildings</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Olaf B. Peterson</b>		14. MOTHER'S MAIDEN NAME <b>Carvilla Perkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>214-16-6351</b>	17. INFORMANT <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RIGHT LUNG WITH METASTASES TO</b> <b>163x</b> <b>PERICARDIAL MEDIASTINAL AND PERI-AORTIC LYMPH NODES,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ADRENALS AND PANCREAS</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANEURISM OF ASCENDING AORTA</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>December 24, 1957</b> , to <b>January 22, 1958</b> , that I was the attending physician, and that death occurred at <b>2:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chien Wei Lan</b>		DATE SIGNED <b>1/22/58</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-25-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetery</b>
22d. LOCATION (City, town, or county) <b>Annapolis, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Taylor &amp; Sons, Annapolis, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JAN 24 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1901		BALTIMORE		MD		USA		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Carpenter		Heart Disease		Natural		JAN 24 1958		BALTIMORE		MD		USA		USA	
EDUCATION		RELIGION		RACE		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY	
High School		Catholic		White		Male		45		JAN 15 1901		BALTIMORE		MD	
MARRIAGE		SPOUSE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY			
Married		Mary H. Harris		JAN 15 1925		BALTIMORE		MD		USA					
PREVIOUS MARRIAGES		PREVIOUS SPOUSES		DATE OF PREVIOUS MARRIAGE		PLACE OF PREVIOUS MARRIAGE		CITY		STATE		COUNTRY			
None		None		None		None		None		None					
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JAN 24 1958		BALTIMORE		MD		USA		USA		JAN 24 1958		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
Heart Disease		Natural		JAN 24 1958		BALTIMORE		MD		USA					
EDUCATION		RELIGION		RACE		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY	
High School		Catholic		White		Male		45		JAN 15 1901		BALTIMORE		MD	
MARRIAGE		SPOUSE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY			
Married		Mary H. Harris		JAN 15 1925		BALTIMORE		MD		USA					
PREVIOUS MARRIAGES		PREVIOUS SPOUSES		DATE OF PREVIOUS MARRIAGE		PLACE OF PREVIOUS MARRIAGE		CITY		STATE		COUNTRY			
None		None		None		None		None		None					
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
JAN 24 1958		BALTIMORE		MD		USA		USA		JAN 24 1958		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
Heart Disease		Natural		JAN 24 1958		BALTIMORE		MD		USA					

RECEIVED  
JAN 24 1958  
BUREAU V. 1

## 240 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Conv. Home</u>				d. STREET ADDRESS <u>Hillside Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stephen (Stanislaw) P. Bugnaski</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 23, 1875</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black &amp; Decker</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown Bugnaski</u>				14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-05-8244</u>		17. INFORMANT Address <u>Mrs. Julia Maynard Hillside Ave. Kingsville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Rectum</u> <u>154x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 2</u> , 19 <u>57</u> , to <u>Jan 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>58</u> , and that death occurred at <u>3:10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Laurence C. Post</u> M.D.				ADDRESS (Street, city or town, state) <u>6005 York Rd Baltimore 12 Md.</u>		DATE SIGNED <u>1-7-58</u>	
PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 9, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephen's</u>		22d. LOCATION (City, town, or county) (State) <u>Bradshaw, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> ADDRESS <u>7401 Belair Rd</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

8361-0 JAN

RECEIVED

## 241 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>2yr11mths2dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lawson</u> <u>Courtney</u> Last <u>Burkins</u>				4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>19 58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Vince Burkins</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonia</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 9</u> , 19 <u>58</u> , to <u>Jan. 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 14</u> , 19 <u>58</u> , and that death occurred at <u>8:55a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachler</u>		M.D. <u>SPRING GROVE STATE HOSPITAL 1-14-58</u>					
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>		<u>Catonsville 28, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 17, 1958</u>		<u>Harford Co Md</u>		<u>Harford Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Bailer</u>				ADDRESS <u>Harlington</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 1958</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES		APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S STATE OF BIRTH		MOTHER'S STATE OF BIRTH		FATHER'S COUNTRY OF BIRTH		MOTHER'S COUNTRY OF BIRTH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S STATE OF DEATH		MOTHER'S STATE OF DEATH	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S STATE OF DEATH		MOTHER'S STATE OF DEATH	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S STATE OF BIRTH		MOTHER'S STATE OF BIRTH		FATHER'S COUNTRY OF BIRTH		MOTHER'S COUNTRY OF BIRTH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S STATE OF DEATH		MOTHER'S STATE OF DEATH	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S STATE OF DEATH		MOTHER'S STATE OF DEATH	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

JAN. 21 1968

RECEIVED

## CERTIFICATE OF DEATH

00228

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HALETHORPE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HOUSE IN THE PINES 16 MUSTING AVE.</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE C. BURKMAN</b>		4. DATE OF DEATH Month Day Year <b>JAN 1 1958</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 5, 1867</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED WATCHMAN WM. J. TICKNERS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>CHARLES BURKMAN</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>25-24-4809</b>	
17. INFORMANT Address <b>MRS MILDRED BRANNICK 4418 RIDGE AVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Decompensation</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio vas. disease</b> DUE TO (c) <b>old age</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>year.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 2</b> , 19 <b>57</b> , to <b>Jan 1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Dec 31</b> , 19 <b>57</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles Columatello</b>		ADDRESS (Street, city or town, state) <b>910 W. Lombard St BALTO, MD.</b>	
DATE SIGNED <b>Jan 3/58</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JAN. 4/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LODON PARK</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WITZKE FUNERAL DIR. 4101 EDMONDSON AVE</b>		24a. REC'D BY REGISTRAR <b>6</b>	24b. REGISTRAR'S SIGNATURE <b>1958</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO.

PLACE OF BIRTH

MARRIAGE

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

NAME OF BURIAL PLACE

DATE OF INTERMENT

NAME OF INTERMENT PLACE

NAME OF PHYSICIAN

DATE OF EXAMINATION

NAME OF EXAMINER

NAME OF CORONER

DATE OF EXAMINATION

NAME OF EXAMINER

NAME OF CORONER

DATE OF EXAMINATION

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DATE OF EXAMINATION

NAME OF EXAMINER

BUREAU V. S.

JAN 6 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00229

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE #14</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethlehem Steel Co. Hospital</b>		d. STREET ADDRESS <b>8301 Oakleigh Rd.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>John</b> Middle <b>S.</b> Last <b>Burns</b>		<b>4. DATE OF DEATH</b> Month <b>1</b> Day <b>2</b> Year <b>19 58</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Feb. 4, 1907</b>
<b>9. AGE</b> (In years last birthday) <b>50</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>50</b> Days <b>50</b>	<b>IF UNDER 24 HRS.</b> Hours <b>50</b> Min. <b>50</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Section Leader - Bethlehem Steel</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Baltimore, Maryland</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>USA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Robert Lee Burns</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Schieswohl</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <b>213-07-2405</b>	
<b>17. INFORMANT</b> <b>Mrs. Lana M. Burns, 8301 Oakleigh Road.</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a) Coronary Occlusion</b>  <b>420.1</b>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)         </div> <div style="width: 15%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH         </div> </div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <b>M. B. Davis</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <b>M. B. Davis, M.D.</b>		<b>DATE SIGNED</b> <b>1/2/58</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>1/6/1958</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood Cemetery</b>	<b>22d. LOCATION (City, town, or county)</b> (State) <b>Baltimore, Maryland</b>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck 5305 Harford Road #14</b>		<b>24a. REC'D BY REGISTRAR</b> <b>1/2/58</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>U. Medrich</b>		<b>DATE</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES H. HARRIS		MALE		35		JAN 6 1903	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS	
CLERK		HIGH SCHOOL		METHODIST		MARRIED	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS	
NONE		NONE		NONE		NONE	
FAMILY HISTORY		FAMILY OCCUPATION		FAMILY RELIGION		FAMILY MARITAL STATUS	
NONE		NONE		NONE		NONE	
FAMILY DEATHS		FAMILY DISEASES		FAMILY INJURIES		FAMILY DRUGS	
NONE		NONE		NONE		NONE	
FAMILY OCCUPATIONS		FAMILY EDUCATIONS		FAMILY RELIGIONS		FAMILY MARITAL STATUSES	
NONE		NONE		NONE		NONE	
FAMILY DEATHS		FAMILY DISEASES		FAMILY INJURIES		FAMILY DRUGS	
NONE		NONE		NONE		NONE	

BUREAU V. S.

JAN 6 1903

RECEIVED

244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ODA</b> First <b>L.</b> Middle <b>BUSK</b> Last <b>(Nee SIRBAUGH)</b>				4. DATE OF DEATH <b>January 17</b> 19 <b>58</b> Month <b>17</b> Day <b>58</b> Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/25/17</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aide</b>				10b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Charles L. Sirbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Mary V. Dowell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO. <b>236-22-5836</b>		17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) CEREBRAL THROMBOSIS</b> <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(2) CORONARY ARTERIOSCLEROSIS</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>36 HOURS</b> UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>January 8</b> , 19 <b>58</b> , to <b>January 17</b> , 19 <b>58</b> , that the cause of death was <b>as stated above</b> , and that death occurred at <b>12 Noon</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Md.</b> DATE SIGNED <b>1/17/58</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH Fort Howard, Md.</b> DATE SIGNED <b>1/17/58</b> PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1-20-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc. 6009 Harford Rd.</b>				24a. REGISTRY REGISTRAR <b>Wm Cook-Blight, Inc. 6009 Harford Rd. Balto. 14, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Wm Cook-Blight, Inc. 6009 Harford Rd. Balto. 14, Md.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		MARRIAGE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES BURKEAU		M		45		JAN 15 1893		BALTIMORE, MD.		MARRIED		LABORER		HEART DISEASE		NATURAL		J. BURKEAU		J. BURKEAU	
RESIDENCE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		URINE		FECES		SIGNATURE OF WITNESS	
1234 E. BALTIMORE ST.		JAN 24 1938		10:00 AM		BALTIMORE, MD.		100.0		80		20		120/80		NORMAL		NORMAL		J. BURKEAU	
EDUCATION		RELIGION		MILITARY SERVICE		PREVIOUS ILLNESS		TREATMENT		HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATION		RADIOLOGICAL EXAMINATION		PATHOLOGICAL EXAMINATION		SIGNATURE OF PATHOLOGIST	
HIGH SCHOOL		CATHOLIC		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		J. BURKEAU	
FAMILY HISTORY		SOCIAL HISTORY		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		SIGNATURE OF PHYSICIAN	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		J. BURKEAU	
FAMILY HISTORY		SOCIAL HISTORY		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		HISTORY OF PRESENT ILLNESS		SIGNATURE OF PHYSICIAN	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		J. BURKEAU	

BURKEAU V. S.

JAN 24 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00231**

**245**

Items 8, 9 Film G224 1-15-58 et

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b> c. LENGTH OF STAY IN 1b <b>1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3021 Balder Avenue (Home)</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b> d. STREET ADDRESS <b>3021 Balder Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>ANDREW</b> Last <b>CALLIS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>10</b> Hours <b>19</b> Min. <b>58</b>	IF UNDER 24 HRS. Months <b>72</b> Days <b>10</b> Hours <b>19</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber—Master</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William T. Callis</b>		14. MOTHER'S MAIDEN NAME <b>Julie ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>422.1</b> (c) <b>422.1</b> DUE TO causing the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		DATE SIGNED <b>1/10/58</b>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 14, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
ADDRESS <b>Towson, Maryland</b>		24b. REGISTRAR'S SIGNATURE	



STATE OF MARYLAND  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

City Baltimore

Residence

3001 Bayview Avenue, Home

Age 55

Sex Male

Married

Occupation

Residence

City

State

Death

At Home

Cause

Heart

Signature

BUREAU V. S.

JAN 13 1933

RECEIVED

246

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>3mths6dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harford, Md.</b>		12X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>87 Fern Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Caroline</b>		First <b>Caroline</b>		Middle <b>Carhart</b>		Last <b>Carhart</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 1, ??</b>	
9. AGE (In years last birthday) <b>84?</b>		IF UNDER 1 YEAR Months <b>84?</b>		IF UNDER 24 HRS. Days <b>84?</b>		Hours <b>84?</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced arteriosclerosis</b> DUE TO (c) <b>Advanced age</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 6, 1957</b> , to <b>Jan. 24, 1958</b> , that I last saw the deceased alive on <b>Jan. 24, 1958</b> , and that death occurred at <b>6:00 p. m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				DATE SIGNED <b>2-5-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>26158</b>		22b. DATE THEREOF <b>2/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>C. of Md. Med. School</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Beach</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

348

REG. NO. 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1880		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
Carpenter		Heart Disease		Natural		Several Weeks		FEB 10 1925		BALTIMORE		MD		USA	
EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		TEMPERATURE		PULSE	
High School		Roman Catholic		White		Caucasian		5' 8"		160 lbs		98.6		72	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
Never Married		Never Married		Never Married		Never Married		Never Married		Never Married		Never Married		Never Married	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISON		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
None		None		None		None		None		None		None		None	
PREVIOUS DEATH		PREVIOUS BURIAL		PREVIOUS CREMATION		PREVIOUS ANATOMY		PREVIOUS ORGAN DONATION		PREVIOUS TRANSPLANT		PREVIOUS CLONE		PREVIOUS REPRODUCTION	
None		None		None		None		None		None		None		None	

BUREAU V. S

FEB 11

RECEIVED

247

## CERTIFICATE OF DEATH

00232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonersville</u>				c. LENGTH OF STAY IN 1b <u>?</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 Wade Ave</u>				d. STREET ADDRESS <u>1 Wade Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Walter O. Carter</u>				4. DATE OF DEATH <u>Jan 12</u> 19 <u>58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 30, 94</u>		9. AGE (In years last birthday) <u>63</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter, ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov + Elec.</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Geo. W. Carter</u>				14. MOTHER'S MAIDEN NAME <u>Clara Ford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>ww I</u>		17. INFORMANT <u>Mary Carter</u> Address <u>(same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>420.1</u> DUE TO <u>Cardiovascular disease &amp; Artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Insufficiency</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Occlusion 2 1/2 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/15</u> , 19 <u>57</u> to <u>1/12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/21</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eliot W Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>3432 Medeiros Ave</u> DATE SIGNED <u>Jan 15 58</u>			
PHYSICIAN'S NAME (Type) <u>Eliot W JOHNSON MD</u>				BALTIMORE 24 ME			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/15/58</u>		<u>Balto. National</u>		<u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Stubb &amp; Son</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 15 58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Stubb</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00233

248

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Kings</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1692 Park Place</b>	
3. NAME OF DECEASED (Type or print) First <b>HYMAN</b> Middle <b>--</b> Last <b>CHAIET</b>		4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1907</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator - Hair Stylist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beauty Parlor</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Michael Chaiet</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Adeleson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>054-01-3681</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hosp., Fort Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ATHEROSCLEROTIC CORONARY ARTERY DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>5 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 5, 1958</b> , to <b>January 8, 1958</b> , and that death occurred at <b>11:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA HOSPITAL, FORT HOWARD, MARYLAND 1/9/58</b>			
ACTUAL SIGNATURE <b>Irving Freeman</b>		PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>1-9-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BROOKLYN N.Y.</b>	22d. LOCATION (City, town, or county) (State) <b>BROOKLYN, N.Y.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto., Md.</b>		24a. REC'D BY REGISTRAR <b>1 JAN 14 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Wm. Cook-Blight</b>			

SHIPPED TO: Kirschenbaum Funeral Home, Coney Island Ave., Corner Ave. J. Brooklyn, N. Y.

JAN 14 1953

RECEIVED

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

249

## CERTIFICATE OF DEATH

Reg. Dist. No.

00234

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Anneslie (Balto. 12)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Anneslie ( Balto. 12 )</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>922 Overbrook Road</b>		d. STREET ADDRESS <b>922 Overbrook Road</b>	
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>CHERRY</b> Last <b>CHERRY</b>		4. DATE OF DEATH Month <b>January</b> Day <b>15,</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 2, 1884</b>
9. AGE (In years last birthday) yrs. <b>73</b>		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Master Sgt. retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.Army</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Honorable discharge papers</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO <b>366x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Muscular Spasms due to acute attack of Neuritis</b> DUE TO (c) <b>to acute attack of Neuritis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/15</b> , 19 <b>57</b> , to <b>1/15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1/15/58</b> , 19 <b>58</b> , and that death occurred at <b>9:30</b> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. M. Smith</b>		ADDRESS (Street, city or town, state) <b>6305 The Clamora</b> DATE SIGNED <b>1/17/58</b>	
PHYSICIAN'S NAME (Type) <b>W. M. Smith</b>		<b>Balto 12, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 20, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons</b>		ADDRESS <b>Towson, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED ANDREW J. BROWN		2. SEX Male		3. AGE 45	
4. DATE OF DEATH JAN 20 1958		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN J. B. Smith	
10. SIGNATURE OF REGISTRAR J. B. Smith		11. SIGNATURE OF WITNESS J. B. Smith		12. SIGNATURE OF DECEASED J. B. Smith	
13. SIGNATURE OF DECEASED J. B. Smith		14. SIGNATURE OF DECEASED J. B. Smith		15. SIGNATURE OF DECEASED J. B. Smith	
16. SIGNATURE OF DECEASED J. B. Smith		17. SIGNATURE OF DECEASED J. B. Smith		18. SIGNATURE OF DECEASED J. B. Smith	
19. SIGNATURE OF DECEASED J. B. Smith		20. SIGNATURE OF DECEASED J. B. Smith		21. SIGNATURE OF DECEASED J. B. Smith	
22. SIGNATURE OF DECEASED J. B. Smith		23. SIGNATURE OF DECEASED J. B. Smith		24. SIGNATURE OF DECEASED J. B. Smith	
25. SIGNATURE OF DECEASED J. B. Smith		26. SIGNATURE OF DECEASED J. B. Smith		27. SIGNATURE OF DECEASED J. B. Smith	
28. SIGNATURE OF DECEASED J. B. Smith		29. SIGNATURE OF DECEASED J. B. Smith		30. SIGNATURE OF DECEASED J. B. Smith	
31. SIGNATURE OF DECEASED J. B. Smith		32. SIGNATURE OF DECEASED J. B. Smith		33. SIGNATURE OF DECEASED J. B. Smith	
34. SIGNATURE OF DECEASED J. B. Smith		35. SIGNATURE OF DECEASED J. B. Smith		36. SIGNATURE OF DECEASED J. B. Smith	
37. SIGNATURE OF DECEASED J. B. Smith		38. SIGNATURE OF DECEASED J. B. Smith		39. SIGNATURE OF DECEASED J. B. Smith	
40. SIGNATURE OF DECEASED J. B. Smith		41. SIGNATURE OF DECEASED J. B. Smith		42. SIGNATURE OF DECEASED J. B. Smith	
43. SIGNATURE OF DECEASED J. B. Smith		44. SIGNATURE OF DECEASED J. B. Smith		45. SIGNATURE OF DECEASED J. B. Smith	
46. SIGNATURE OF DECEASED J. B. Smith		47. SIGNATURE OF DECEASED J. B. Smith		48. SIGNATURE OF DECEASED J. B. Smith	
49. SIGNATURE OF DECEASED J. B. Smith		50. SIGNATURE OF DECEASED J. B. Smith		51. SIGNATURE OF DECEASED J. B. Smith	
52. SIGNATURE OF DECEASED J. B. Smith		53. SIGNATURE OF DECEASED J. B. Smith		54. SIGNATURE OF DECEASED J. B. Smith	
55. SIGNATURE OF DECEASED J. B. Smith		56. SIGNATURE OF DECEASED J. B. Smith		57. SIGNATURE OF DECEASED J. B. Smith	
58. SIGNATURE OF DECEASED J. B. Smith		59. SIGNATURE OF DECEASED J. B. Smith		60. SIGNATURE OF DECEASED J. B. Smith	
61. SIGNATURE OF DECEASED J. B. Smith		62. SIGNATURE OF DECEASED J. B. Smith		63. SIGNATURE OF DECEASED J. B. Smith	
64. SIGNATURE OF DECEASED J. B. Smith		65. SIGNATURE OF DECEASED J. B. Smith		66. SIGNATURE OF DECEASED J. B. Smith	
67. SIGNATURE OF DECEASED J. B. Smith		68. SIGNATURE OF DECEASED J. B. Smith		69. SIGNATURE OF DECEASED J. B. Smith	
70. SIGNATURE OF DECEASED J. B. Smith		71. SIGNATURE OF DECEASED J. B. Smith		72. SIGNATURE OF DECEASED J. B. Smith	
73. SIGNATURE OF DECEASED J. B. Smith		74. SIGNATURE OF DECEASED J. B. Smith		75. SIGNATURE OF DECEASED J. B. Smith	
76. SIGNATURE OF DECEASED J. B. Smith		77. SIGNATURE OF DECEASED J. B. Smith		78. SIGNATURE OF DECEASED J. B. Smith	
79. SIGNATURE OF DECEASED J. B. Smith		80. SIGNATURE OF DECEASED J. B. Smith		81. SIGNATURE OF DECEASED J. B. Smith	
82. SIGNATURE OF DECEASED J. B. Smith		83. SIGNATURE OF DECEASED J. B. Smith		84. SIGNATURE OF DECEASED J. B. Smith	
85. SIGNATURE OF DECEASED J. B. Smith		86. SIGNATURE OF DECEASED J. B. Smith		87. SIGNATURE OF DECEASED J. B. Smith	
88. SIGNATURE OF DECEASED J. B. Smith		89. SIGNATURE OF DECEASED J. B. Smith		90. SIGNATURE OF DECEASED J. B. Smith	
91. SIGNATURE OF DECEASED J. B. Smith		92. SIGNATURE OF DECEASED J. B. Smith		93. SIGNATURE OF DECEASED J. B. Smith	
94. SIGNATURE OF DECEASED J. B. Smith		95. SIGNATURE OF DECEASED J. B. Smith		96. SIGNATURE OF DECEASED J. B. Smith	
97. SIGNATURE OF DECEASED J. B. Smith		98. SIGNATURE OF DECEASED J. B. Smith		99. SIGNATURE OF DECEASED J. B. Smith	
100. SIGNATURE OF DECEASED J. B. Smith		101. SIGNATURE OF DECEASED J. B. Smith		102. SIGNATURE OF DECEASED J. B. Smith	

BUREAU V. S.

JAN 20 1958

RECEIVED

250

CERTIFICATE OF DEATH

Reg. Dist. No.

00235

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b> c. LENGTH OF STAY IN 1b <b>6 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elk Mills</b> d. STREET ADDRESS <b>Maryland</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lois</b> Middle <b>Janette</b> Last <b>Clark</b>		4. DATE OF DEATH Month <b>1</b> Day <b>30</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/21/53</b>
9. AGE (In years last birthday) <b>4</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>30</b> Hours <b>19</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vaughn Clark</b>		14. MOTHER'S MAIDEN NAME <b>Ruth L. Phillips</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Rosewood Records</b>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacillary Dysentery</b> DUE TO <b>Arnold Chiari Syndrome</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arnold Chiari Syndrome</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>4:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rosewood State Training School</b> DATE SIGNED <b>1/30/58</b>			
ACTUAL SIGNATURE <b>Harry G. Butler</b>		M.D. <b>Rosewood State Training School</b>	
PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>2-2-58</b>	<b>Clark Cemetery</b>	<b>LANSING, N.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Elmer &amp; Sons</b>		ADDRESS <b>Reisterstown Md.</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<b>FEB 3 58</b>		<b>W. F. Seabach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED  
FEB 3 1958  
BUREAU V. S.

251

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN TB <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. STREET ADDRESS <u>Bird River Road Box 117 Rt 16</u>			
3. NAME OF DECEASED (Type or print) First <u>ANTHONY</u> Middle <u>J.</u> Last <u>CLAY</u>				4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/17/92</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Michael Clay</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Petro</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>220-20-3067</u>		17. INFORMANT <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA WITH METASTASES TO HILAR</u> <u>LYMPH NODES AND LIVER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DO NOT KNOW</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>January 11, 19 58</u> to <u>January 20, 19 58</u> and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chien Wei Lan</u>				ADDRESS (Street, city or town, state) <u>VAH Fort Howard, Md.</u>			
PHYSICIAN'S NAME (Type) <u>CHIEN WEI LAN, M. D.</u>				DATE SIGNED <u>1/20/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>1-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

22

BUREAU OF THE ARMY

JAN 24 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

252

## CERTIFICATE OF DEATH

00237

Item 2, Film G224, 1/21/58

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN b <u>19 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> <u>3401.4</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> <u>4212 Tuscany Court</u> d. STREET ADDRESS <u>Rosewood Training School</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Karen</u> Middle <u>Cooper</u> Last <u>Cooper</u>		4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>19 58</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/36</u>	9. AGE (In years last birthday) <u>21</u> yrs.	IF UNDER 1 YEAR: Months <u>1</u> Days <u>8</u> Hours <u>19</u> Min. <u>58</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Howard E. Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Eigler</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Rosewood Records</u>		17. INFORMANT Address <u>Rosewood Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central failure of respiration</u> 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain swelling</u> DUE TO (c) <u>Congenital brain damage (nature to be determined after fixation)</u>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8:25 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1/8/58</u>							
ACTUAL SIGNATURE <u>Dr. Rich. Linderberg</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Rich. Linderberg</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>1/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Crem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker &amp; Sons - North Pa. Aves. - 17</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Tucker</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 10 1958

RECEIVED

JAN 13 1953

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1  
TO BE FILLED BY THE REGISTRAR OF DEATHS  
TO BE RETURNED TO THE REGISTRAR OF DEATHS  
TO BE RETURNED TO THE REGISTRAR OF DEATHS



253  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b <u>6 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u> x			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3024 California Ave.</u>				d. STREET ADDRESS <u>Greenpasture Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET - C - CORBIN</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17, 1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John POPP</u>				14. MOTHER'S MAIDEN NAME <u>Rachel GREEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>John Corbin</u> Address <u>Greenpasture Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. cardio-vascular-renal dis.</u> DUE TO (c) <u>5 yrs +</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan. 29</u> , 19 <u>58</u> to <u>Jan. 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 29</u> , 19 <u>58</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. M. Bacon</u>				M.D. <u>2810 Taylor Ave.</u>			
PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Providence</u>		22d. LOCATION (City, town, or county) (State) <u>Providence</u> <u>MD</u>	
23. FLINERAL DIRECTOR'S SIGNATURE <u>CHAR. F. TRANSDON</u>				ADDRESS <u>8802 HARFORD RD</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Overman</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00239

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4yr 3mth 1dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5365 Pumphrey Drive - Washington 25, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>			d. STREET ADDRESS <b>5365 Pumphrey Drive 16X-2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Brainard</b> Last <b>Daniels</b>			4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1958</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 13, 1879</b>		9. AGE (In years last birthday) <b>78</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>	
13. FATHER'S NAME <b>Walter Daniels</b>			14. MOTHER'S MAIDEN NAME <b>Lena</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>313-03-2751</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> <b>903.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Pneumonia</b> (a), stating the underlying cause lost. (c) <b>fractured left femur</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>493+</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Patient was pushed to floor by another patient, sustaining frac. of left femur</b>			
20c. TIME OF INJURY Month, Day, Year <b>5:30 P.M. 12-27-1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) <b>Catonsville 28, Maryland</b>	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>George M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Jan 17-58</b>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/21/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Tranite City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mac Gubb &amp; Son</b>			24a. REC'D BY REGISTRAR DATE <b>JAN 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

ARMY AND NAVAL DEPARTMENT OF HEALTH - BUREAU OF

BUREAU V. S.

JAN 20 1953

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>222 Cherry Dell Rd.</b>		d. STREET ADDRESS <b>222 Cherry Dell Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Richard M. Dashiell</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>1</b> Year <b>19 58</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1896</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New Joyce Hotel</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>T. Dashiell</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>212-09-9437</b>		16. SOCIAL SECURITY NO. <b>212-09-9437</b>	
17. INFORMANT <b>Mrs. Donna Zink. 222 Cherry Dell Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Acute Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular disease chronic</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Geo. S. M. Kieffer</b>		DATE SIGNED <b>Jan. 1, 1958</b>	
EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M.D</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JAN. 4/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WITZKE FUNERAL DIR. 4101 EDMONDSON AVE.</b>		24a. REC'D BY REGISTRAR <b>JAN 3 1958</b>	24b. REGISTRAR'S SIGNATURE <b>G. W. Medvedy</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

AN 3 1958

BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00241

256

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>710 Elmwood Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mr. Thomas E. Davey</u> Middle <u>E.</u> Last <u>Davey</u>				4. DATE OF DEATH Month <u>January</u> Day <u>28th</u> Year <u>19 58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 11, 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>James Davey</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Finn</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>217-01-0931A</u>				17. INFORMANT Address <u>Mr. Thomas J. Davey, 718 Elmwood Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LARYNX</u> <u>161X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>161X</u> DUE TO (c) <u>161X</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>AUG. 26</u> , 19 <u>56</u> , to <u>JAN. 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN. 27</u> , 19 <u>58</u> , and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Adam Swiss</u> M.D.				ADDRESS (Street, city or town, state) <u>6232 Belair Road</u> DATE SIGNED <u>1/28/58</u>			
PHYSICIAN'S NAME (Type) <u>Adam Swiss</u>				Baltimore, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy R deemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>DATE JAN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Ruck</u>	

JAN 30 1951

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5313 W. North Ave.</b>		d. STREET ADDRESS <b>5313 W. North Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>M.</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>26</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Linesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown Davis</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Ada L. Davis - 5313 W. North Ave., Woodlawn</b>		Address <b>Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Co Pulmonale</b> <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Co Pulmonale</b> DUE TO (c) <b>Emphysema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>sev. years</b> <b>sev. year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/13</b> 19 <b>58</b> , to <b>1/26</b> 19 <b>58</b> , that I last saw the deceased alive on <b>1/17</b> 19 <b>58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1/27/58</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Herz J. Miller MD</b> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/29/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>	22d. LOCATION (City, town, or county) (State) <b>Elkridge, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Pickner &amp; Sons - Balt. 17th</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 27 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. J. Pickner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES J. JONES		Male		35		1900		New York City, N.Y.	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
Teacher		Heart Disease		Natural		Home		10:30 AM	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 28 1933

RECEIVED



203

## CERTIFICATE OF DEATH

00243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 DUNDALK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>61 DUNDALK AVE</b>		d. STREET ADDRESS <b>161 DUNDALK AVE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NORA LEE MORRIS DAVIS</b>		4. DATE OF DEATH Month Day Year <b>1-13-58 19</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 22, 1881</b>
9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN MORRIS</b>		14. MOTHER'S MAIDEN NAME <b>MARY M. SHIFFLETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or other) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NOVIS</b>	
17. INFORMANT <b>MRS. H.L. SNEAD - SAME</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b> <b>15 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 16, 1956</b> to <b>Jan 13, 1958</b> , that I last saw the deceased alive on <b>Jan 12, 1958</b> , and that death occurred at <b>6:35 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David H. Andrew</b> M.D.		ADDRESS (Street, city or town, state) <b>33 Dundalk Ave Dundalk, Md.</b> DATE SIGNED <b>1/13/58</b>	
PHYSICIAN'S NAME (Type) <b>David H. Andrew</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/16/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MONTECELLO MEM. PK</b>	22d. LOCATION (City, town, or county) (State) <b>CHARLOTESVILLE VA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Hugh Brockley, Dundalk, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 15 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Brockley</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1953</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. DATE OF BIRTH <i>Jan 15 1908</i>		11. TIME OF BIRTH <i>10:30 AM</i>		12. PLACE OF BIRTH <i>Baltimore, Md.</i>	
13. NAME OF FATHER <i>John Doe</i>		14. NAME OF MOTHER <i>John Doe</i>		15. NAME OF SPOUSE <i>John Doe</i>	
16. NAME OF CHILDREN <i>John Doe</i>		17. NAME OF CHILDREN <i>John Doe</i>		18. NAME OF CHILDREN <i>John Doe</i>	
19. NAME OF CHILDREN <i>John Doe</i>		20. NAME OF CHILDREN <i>John Doe</i>		21. NAME OF CHILDREN <i>John Doe</i>	
22. NAME OF CHILDREN <i>John Doe</i>		23. NAME OF CHILDREN <i>John Doe</i>		24. NAME OF CHILDREN <i>John Doe</i>	
25. NAME OF CHILDREN <i>John Doe</i>		26. NAME OF CHILDREN <i>John Doe</i>		27. NAME OF CHILDREN <i>John Doe</i>	
28. NAME OF CHILDREN <i>John Doe</i>		29. NAME OF CHILDREN <i>John Doe</i>		30. NAME OF CHILDREN <i>John Doe</i>	
31. NAME OF CHILDREN <i>John Doe</i>		32. NAME OF CHILDREN <i>John Doe</i>		33. NAME OF CHILDREN <i>John Doe</i>	
34. NAME OF CHILDREN <i>John Doe</i>		35. NAME OF CHILDREN <i>John Doe</i>		36. NAME OF CHILDREN <i>John Doe</i>	
37. NAME OF CHILDREN <i>John Doe</i>		38. NAME OF CHILDREN <i>John Doe</i>		39. NAME OF CHILDREN <i>John Doe</i>	
40. NAME OF CHILDREN <i>John Doe</i>		41. NAME OF CHILDREN <i>John Doe</i>		42. NAME OF CHILDREN <i>John Doe</i>	
43. NAME OF CHILDREN <i>John Doe</i>		44. NAME OF CHILDREN <i>John Doe</i>		45. NAME OF CHILDREN <i>John Doe</i>	
46. NAME OF CHILDREN <i>John Doe</i>		47. NAME OF CHILDREN <i>John Doe</i>		48. NAME OF CHILDREN <i>John Doe</i>	
49. NAME OF CHILDREN <i>John Doe</i>		50. NAME OF CHILDREN <i>John Doe</i>		51. NAME OF CHILDREN <i>John Doe</i>	
52. NAME OF CHILDREN <i>John Doe</i>		53. NAME OF CHILDREN <i>John Doe</i>		54. NAME OF CHILDREN <i>John Doe</i>	
55. NAME OF CHILDREN <i>John Doe</i>		56. NAME OF CHILDREN <i>John Doe</i>		57. NAME OF CHILDREN <i>John Doe</i>	
58. NAME OF CHILDREN <i>John Doe</i>		59. NAME OF CHILDREN <i>John Doe</i>		60. NAME OF CHILDREN <i>John Doe</i>	
61. NAME OF CHILDREN <i>John Doe</i>		62. NAME OF CHILDREN <i>John Doe</i>		63. NAME OF CHILDREN <i>John Doe</i>	
64. NAME OF CHILDREN <i>John Doe</i>		65. NAME OF CHILDREN <i>John Doe</i>		66. NAME OF CHILDREN <i>John Doe</i>	
67. NAME OF CHILDREN <i>John Doe</i>		68. NAME OF CHILDREN <i>John Doe</i>		69. NAME OF CHILDREN <i>John Doe</i>	
70. NAME OF CHILDREN <i>John Doe</i>		71. NAME OF CHILDREN <i>John Doe</i>		72. NAME OF CHILDREN <i>John Doe</i>	
73. NAME OF CHILDREN <i>John Doe</i>		74. NAME OF CHILDREN <i>John Doe</i>		75. NAME OF CHILDREN <i>John Doe</i>	
76. NAME OF CHILDREN <i>John Doe</i>		77. NAME OF CHILDREN <i>John Doe</i>		78. NAME OF CHILDREN <i>John Doe</i>	
79. NAME OF CHILDREN <i>John Doe</i>		80. NAME OF CHILDREN <i>John Doe</i>		81. NAME OF CHILDREN <i>John Doe</i>	
82. NAME OF CHILDREN <i>John Doe</i>		83. NAME OF CHILDREN <i>John Doe</i>		84. NAME OF CHILDREN <i>John Doe</i>	
85. NAME OF CHILDREN <i>John Doe</i>		86. NAME OF CHILDREN <i>John Doe</i>		87. NAME OF CHILDREN <i>John Doe</i>	
88. NAME OF CHILDREN <i>John Doe</i>		89. NAME OF CHILDREN <i>John Doe</i>		90. NAME OF CHILDREN <i>John Doe</i>	
91. NAME OF CHILDREN <i>John Doe</i>		92. NAME OF CHILDREN <i>John Doe</i>		93. NAME OF CHILDREN <i>John Doe</i>	
94. NAME OF CHILDREN <i>John Doe</i>		95. NAME OF CHILDREN <i>John Doe</i>		96. NAME OF CHILDREN <i>John Doe</i>	
97. NAME OF CHILDREN <i>John Doe</i>		98. NAME OF CHILDREN <i>John Doe</i>		99. NAME OF CHILDREN <i>John Doe</i>	
100. NAME OF CHILDREN <i>John Doe</i>		101. NAME OF CHILDREN <i>John Doe</i>		102. NAME OF CHILDREN <i>John Doe</i>	

RECEIVED  
JAN 15 1953  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00244

Reg. Dist. No.

258

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>42 Bond Ave.</b>		d. STREET ADDRESS <b>42 Bond Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>Mamie</b> Last <b>Dett</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>27</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1891</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Burgess</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Joshua L. Dett, Bond Ave. Reisterstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>592x</b> DUE TO <b>Chronic Nephritis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>5 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-23-57</b> , 19___, to <b>1-27-58</b> , 19___, that I last saw the deceased alive on <b>1-25-58</b> , 19___, and that death occurred at <b>7 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Rd. Reisterstown, Md.</b> DATE SIGNED <b>1-29-58</b>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. <b>6 Hanover Rd. Reisterstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 30, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes</b>	22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 3 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. J. Beach</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

259

## CERTIFICATE OF DEATH

00245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Evelyn L. Dolly</i>		4. DATE OF DEATH <i>Jan 7th 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 6-1925</i>
9. AGE (In years last birthday) <i>32</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Kaylor</i>		14. MOTHER'S MAIDEN NAME <i>Emma</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Earl Dolly</i>		Address <i>(Same)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic Carcinoma</i> <i>171X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cancer of cervix</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> <i>2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1955</i> to <i>1/3/58</i> , that I last saw the deceased alive on <i>1/2 1958</i> , and that death occurred at <i>330 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Joseph Jaenen</i> M.D. <i>1515- Martin Blvd #20</i>		<i>1/2/58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John B. Connelly</i>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <i>JAN 23 '58</i>			



CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

MARYLAND

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESS

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CLERK

18. SIGNATURE OF DECEASED

BUREAU V. 1

JAN 23 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00246

260

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		d. STREET ADDRESS <b>3820 Oak Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>V.</b> Last <b>DONAHUE</b>		4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1874</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Conewago, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Dougherty</b>		14. MOTHER'S MAIDEN NAME <b>Mary McDonald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Raymond J. Donahue-3820 Oak Avenue</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIO</b> <b>422.1</b> DUE TO <b>VASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January, 1950</b> , to <b>1/13, 1958</b> , that I last saw the deceased alive on <b>1/13, 1958</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3629 Edmondson Rd. Baltimore, Md.</b> DATE SIGNED <b>1/14/58</b>			
ACTUAL SIGNATURE <b>Thomas E. Roach</b> M.D.		DATE SIGNED <b>1/14/58</b>	
PHYSICIAN'S NAME (Type) <b>Thomas E. Roach, M.D.</b>		ADDRESS <b>3629 Edmondson Avenue</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/17/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		ADDRESS <b>Ellsworth Armacost-4600 Liberty Hgts. Ave.</b>	
24a. REC'D BY REGISTRAR <b>JAN 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Roach</b>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

261

## CERTIFICATE OF DEATH

00247

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>8 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Estella</b> Middle <b>I.</b> Last <b>Dushane</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>3</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 20, 1875</b>
9. AGE (In years last birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>	IF UNDER 24 HRS. Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Howard Co. Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Howard Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Howard Co. Maryland</b>	
13. FATHER'S NAME <b>Charles H. Walter</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Blackburn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>James H. Dushane</b>		Address <b>3408 Grantley Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Decompensation</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chr. Hypertensive Cardio-Vascular-Renal Disease</b> DUE TO (c) <b>1.53</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-30-1957</b> to <b>1-3-1958</b> , that I last saw the deceased alive on <b>1-2-1958</b> , and that death occurred at <b>10:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6309 Frederick Ave., Baltimore, Md.</b> DATE SIGNED <b>1/4/58</b>			
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>		M.D. <b>6309 Frederick Ave., Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>		<b>Baltimore, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 6, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. W. Mears &amp; Son 805 N. Calvert St.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE <b>H. W. Mears</b>		24c. REGISTRAR'S SIGNATURE <b>H. W. Mears</b>	

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with  
the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00248

262

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>9mths16dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>5628 Loch Raven Blvd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Duvall</b> Last <b>Duvall</b>		4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 26, 1876</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>freight</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Duvall</b>		14. MOTHER'S MAIDEN NAME <b>Hester Sellers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>216-09-2217</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 21, 1956</b> , to <b>Jan. 16, 1958</b> , that I last saw the deceased alive on <b>Jan. 16, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Stella Wachsler</b> M.D. <b>SPRING GROVE STATE HOSPITAL 1-16-58</b> PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b> <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-18-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Landon Pk Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McGilly Funeral Homes</b>		ADDRESS <b>Balto Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 2-8-58</b>		24b. REGISTRAR'S SIGNATURE <b>D. L. ...</b>	



BUREAU V. S.

JAN 20 1958

RECEIVED

263

## CERTIFICATE OF DEATH

Reg. Dist. No.

00249

1. PLACE OF DEATH a. COUNTY <b>Baltimore County,</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>7 Yrs. 7 Mos. 2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sheppard and Enoch Pratt Hospital</b>				d. STREET ADDRESS <b>2736 North Calvert Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Kathryn</b> Middle <b>Happ</b> Last <b>Eastland</b>				4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 14, 1866</b>	9. AGE (In years lost birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>John Happ</b>				14. MOTHER'S MAIDEN NAME <b>Mary Pope</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocardial degeneration</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senility</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>10 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Brain Disease; Influenza 480x</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 19, 1950</b> , to <b>Jan 21, 1958</b> , that I last saw the deceased alive on <b>Jan 20, 1958</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. W. Elgin</b>				ADDRESS (Street, city or town, state) <b>Sheppard Pratt Hosp. Towson - 4. Md.</b>			
PHYSICIAN'S NAME (Type) <b>W. W. Elgin</b>				DATE SIGNED <b>Jan 21, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1/22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>County Line</b>		22d. LOCATION (City, town, or county) (State) <b>Alden, N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner</b>				ADDRESS <b>Wm. J. Lickner</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 23 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. J. Lickner</b>			

# CERTIFICATE OF DEATH

STATE OF MARYLAND		COUNTY OF BALTIMORE	
DECEASED		DATE OF DEATH	
NAME OF DECEASED		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		CAUSE OF DEATH	
PLACE OF DEATH		DATE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF MINISTER	
NAME OF NEXT OF KIN		NAME OF WITNESS	
SIGNATURE OF DECEASED		SIGNATURE OF MINISTER	
SIGNATURE OF WITNESS		SIGNATURE OF FUNERAL HOME	

BUREAU V. 2

JAN 23 1959

RECEIVED

## CERTIFICATE OF DEATH

00250

Reg. Dist. No.

264

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>		c. LENGTH OF STAY IN 1b <b>21 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROSEWOOD STATE TRAINING SCHOOL</b>		d. STREET ADDRESS <b>—</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BELINDA</b> Middle <b>LEE</b> Last <b>ECKHART</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 20, 1955</b>
9. AGE (In years last birthday) <b>2 yrs.</b>		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	IF UNDER 24 HRS. Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>ROBERT WILLIAM ECKHART</b>		14. MOTHER'S MAIDEN NAME <b>BETTY LEE TWIGG</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>ROSEWOOD RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONITIS</b> <b>753.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CONGENITAL CEREBRAL DEFECT WITH CONVULSION</b> DUE TO (c) <b>Since birth</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4-days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>12:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1/20/58</b>			
ACTUAL SIGNATURE <b>Rich. Lindenberg (Pathologist)</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Rich. Lindenberg (Pathologist)</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 22, 58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Truss Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Eckhart, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 22 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>—</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN		16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CEMETERY		19. SIGNATURE OF CHURCH		20. SIGNATURE OF OTHER					

RECEIVED  
JAN 22 1969  
BUREAU V. S.

THIS IS A PRELIMINARY REPORT OF THE DEATH OF THE DECEASED. IT IS NOT A FINAL REPORT. IT IS SUBJECT TO CORRECTION. THE FINAL REPORT WILL BE FURNISHED TO THE BUREAU OF VITAL STATISTICS. THE BUREAU OF VITAL STATISTICS WILL BE RESPONSIBLE FOR THE CORRECTION OF THE FINAL REPORT. THE BUREAU OF VITAL STATISTICS WILL BE RESPONSIBLE FOR THE CORRECTION OF THE FINAL REPORT. THE BUREAU OF VITAL STATISTICS WILL BE RESPONSIBLE FOR THE CORRECTION OF THE FINAL REPORT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01581

265

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1 yr 4 mths</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles Sidney Edmonds, II</b>		4. DATE OF DEATH <b>Jan. 21 1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1917</b>
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>requisition clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Stuart Edmonds</b>	
14. MOTHER'S MAIDEN NAME <b>Wood G. Edmonds Garner</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>350x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Parkinson's Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 13</b> 1958, to <b>Jan. 21</b> 1958, that I last saw the deceased alive on <b>Jan. 21</b> 1958, and that death occurred at <b>11:52p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>1-22-58</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>1/24/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Christ Church</b>	22d. LOCATION (City, town, or county) (State) <b>Chapin Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McClary Mattingly</b>		ADDRESS <b>Leonardtown, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form 100-100

Form 100-100 (Certificate of Death) fields including: Name, Sex, Age, Race, Date of Birth, Date of Death, Cause of Death, Place of Death, and Registrar's Signature.

BURIAL Y. B.

JAN 24 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 266  
 CERTIFICATE OF DEATH

00251

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>5 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>718 Westhills Parkway</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RUSSELL SMITH ELLIS</u>				4. DATE OF DEATH <u>Jan 31 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 31 1898</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer &amp; Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lasting Products</u>		11. BIRTHPLACE (State or foreign country) <u>Newburg W. Va</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Clarence P. Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Maudie E. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>705-05-0873</u>		17. INFORMANT <u>Mildred L. Ellis - 718 Westhills Parkway</u> Address <u>29</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>481X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aneurysm</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>5 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 29</u> , 19 <u>58</u> , to <u>Jan 31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 29</u> , 19 <u>58</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Jan 31/58</u>							
ACTUAL SIGNATURE <u>Dr. E. R. Dorn</u> M.D.							
PHYSICIAN'S NAME (Type) <u>6 Earl Biddle St Baltimore Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Feb 3-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>	
22d. LOCATION (City, town, or county) <u>Fessups</u>				(State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Tenfel</u>				ADDRESS <u>5311 Edmondson Ave</u>		24a. REC'D BY REGISTRAR <u>Feb 3 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alberich</u>			

BUREAU V. S.

33 3 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filled with the registration information prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

267

## CERTIFICATE OF DEATH

Reg. Dist. No.

00252

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>31 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>Old Hanover Road.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>OSBORN</b> Middle <b>M.</b> Last <b>ENSOR</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 30, 1917</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Arthur Ensor</b>				14. MOTHER'S MAIDEN NAME <b>Edna Osborn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW II</b>				16. SOCIAL SECURITY NO. <b>212-10-8082</b>		17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONJESTIVE FAILURE</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RHEUMATIC HEART DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <b>VA</b> attended the deceased from <b>December 4, 19 57</b> , to <b>January 4, 19 58</b> and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MD.</b> DATE SIGNED <b>1/4/58</b> ACTUAL SIGNATURE <b>Garfield D. KINGTON, M.D.</b> PHYSICIAN'S NAME (Type) <b>Garfield D. KINGTON, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/8/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial Gardens Finksberg, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

James Eline &amp; Sons, 10 Main St., Reisterstown, Md.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18







CERTIFICATE OF DEATH

Form 100-100

BUREAU V. S.

FEB 3 1958

RECEIVED

269

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>2017 Wells Manor Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>Lee</u> Last <u>Farley</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 21 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Insurance Agent Prudential Co</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles F. Farley</u>				14. MOTHER'S MAIDEN NAME <u>Lillian F. Farley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				17. INFORMANT <u>Lillian F. Farley 2017 Wells Manor Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension C. V. disease</u> DUE TO (c) <u>Pulmonary Embolism</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002x Pulmonary Tuberculosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1957</u> , to <u>1957</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Louis D. Alkan</u> M.D. <u>1/11/58</u> <u>Robert E. Red</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>Jan 14 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Amos</u>				4204 Ridgewood Ave		24a. REC'D BY REGISTRAR DATE <u>JAN 14 58</u>	
				24b. REGISTRAR'S SIGNATURE			



270

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park, Md.</u> <u>16x-2</u>			
c. LENGTH OF STAY IN 1b <u>4yrl0mths8dys</u>				d. STREET ADDRESS <u>40 - 65th Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Allice</u> Last <u>Ferguson</u>				4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>19 58</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 12, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Randolph Inset INSCOE</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Ferguson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> <u>443X</u> DUE TO <u>Cerebral vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> (c) <u>with arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 17</u> , 19 <u>58</u> , to <u>Jan. 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 22</u> , 19 <u>58</u> , and that death occurred at <u>5:48p</u> M, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>1-23-58</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-25-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers</u> ADDRESS <u>Washington D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 27 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

RECEIVED

BUREAU V. S.

JAN 27 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

271

## CERTIFICATE OF DEATH

00256

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN TB <b>1yr3mos</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood St. Training School</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> 1526.2	
3. NAME OF DECEASED (Type or print) First <b>Robert Joseph Finn</b> Middle Last		4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 23 1955</b>
9. AGE (In years last birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Capt. John L. Finn</b>		14. MOTHER'S MAIDEN NAME <b>Frances Tipton Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records Rosewood State Tr. School</b>		Address <b>Owings Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pneumonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <del>Rubeola</del> <b>Rubeola</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mongolism with Congenital Heart Disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 20</b> , 19 <b>58</b> , to <b>Jan. 25</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>January 25</b> , 19 <b>58</b> , and that death occurred at <b>7:35pm</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Viola B. Johns</b> M.D.		Rosewood State Tr. School <b>1/25/58</b>	
PHYSICIAN'S NAME (Type) <b>Viola B. Johns, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		22b. DATE THEREOF <b>1/27/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hollidaysburg</b>		22d. LOCATION (City, town, or county) (State) <b>Hollidaysburg, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>JAN 28 58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 28 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00257

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO 19</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2511 Menner Ave</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. 19</u> d. STREET ADDRESS <u>2511 Menner Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>BETTY</u> First <u>JEAN</u> Middle <u>FISHER</u> Last		<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>30</u> Year <u>58</u>		<b>5. SEX</b> <u>F.</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12/26/1957</u>		<b>9. AGE</b> (in years last birthday) <u>1</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>JOHN H. FISHER</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>DOROTHY M. GIBSON</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>—</u>				<b>17. INFORMANT</b> <u>J. H. FISHER</u> Address <u>SAME</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c), stating the underlying cause last. DUE TO <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>																INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>—</u> o. m. <u>19</u> p. m.				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																			
<b>ACTUAL SIGNATURE</b> <u>Jack E. Collins</u>										<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>1-30-58</u>					
<b>EXAMINER'S NAME (Type)</b> <u>JACK E. COLLINS</u>										<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burn</u>				<b>22b. DATE THEREOF</b> <u>1/31/58</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>BALTO. NAT.</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>BALTO. MD</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter R. Ruddy, Howard, MD</u>										<b>24a. REC'D BY REGISTRAR</b> <u>Feb 3 '58</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. R. Ruddy</u>					

2034336XV3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FEB 3 1958

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate (24)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate (24)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7509 Lange Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Martha Madaline Fisher</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1912</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Virgil Schwan</b>		14. MOTHER'S MAIDEN NAME <b>2 2</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>267-14-1271</b>	
17. INFORMANT <b>John R. Fisher</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>420.1</b> DUE TO causing the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fire</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis M.D.</b>		DATE SIGNED <b>1/11/58</b>	
EXAMINER'S NAME (Type) <b>M. B. DAVIS M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/13/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Bruzdinski</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 13 58</b>	
ADDRESS <b>1407 Eastern Ave. Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Cliff Leach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature. The form is oriented horizontally but contains vertical text on the left side.

BUREAU V. S.

JAN 13 1938

RECEIVED



Items 18&21 Film 225 2-5-58  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn, Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>304 Washburn Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Susie</b> Middle <b>Fisher</b> Last <b>Fisher</b>		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>	IF UNDER 24 HRS. Hours <b>82</b> Min. <b>82</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Address</b>	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Pyelonephritis &amp; nephrolithiasis</b> DUE TO (c) <b>602x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>902.7</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. slipped from chair striking right side of forehead.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>2:35</b> P. M. <b>1-7</b> 19 <b>58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>		20f. (City or town) (County) (State) <b>Catonsville 28, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>George M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		DATE SIGNED <b>1-10-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1-24-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SPRING GROVE STATE HOSP - Catonsville 28, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Catonsville 28, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Address</b>		24a. REC'D BY REGISTRAR <b>JAN 31 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

10501  
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BURMAN M. A.

JAN 31 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sparrows Point Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>4023 Deepwood Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>MASON</b> Last <b>FITZPATRICK</b>		4. DATE OF DEATH Month <b>1</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 23, 1897</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Superintendent of</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Blooming Mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Beth. Steel Co. Charles F. Fitz-Patrick</b>		14. MOTHER'S MAIDEN NAME <b>Belle Newman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Mary F. Fitz-Patrick</b>		Address <b>4023 Deepwood Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>430.1</b> DUE TO (b) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Coronary Occlusion</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>NONE</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M. B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D.</b>		DATE SIGNED <b>1/15/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>Jan. 18, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>		ADDRESS <b>1900 Eutaw Place</b>	
24a. REC'D BY REGISTRAR <b>JAN 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JAN 17 1953  
BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No.

276

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix (Rural)</b>		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paper Mill Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>Barrett</b> Last <b>Ford</b>		4. DATE OF DEATH Month <b>1-9-58</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-18-1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Barrett</b>		14. MOTHER'S MAIDEN NAME <b>Cecelia Greece</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Chas. E. Ford, Sr., Phoenix, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio Vascular Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 4<sup>th</sup></b> , 19 <b>58</b> , to <b>JAN 9<sup>th</sup></b> , 19 <b>58</b> , that I last saw the deceased alive on <b>JAN. 9<sup>th</sup></b> , 19 <b>58</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1927 YORK RD, TIMONIUM, Md.</b> DATE SIGNED <b>1-10-58</b>			
ACTUAL SIGNATURE <b>M. K. Quinn M.D.</b>		PHYSICIAN'S NAME (Type) <b>M. K. QUINN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-12-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Scott Brooks</b>		ADDRESS <b>622 York Rd., Towson 4, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 13 1938

BUREAU V. S.

622 York St., Newark, N.J.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

277

CERTIFICATE OF DEATH

00262

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2908 Hillcrest Avenue</u>				d. STREET ADDRESS <u>2908 Hillcrest Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Job</u> Middle <u>M.</u> Last <u>Fosler</u>		4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1958</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 28, 1886</u>	9. AGE (In years last birthday) yrs. <u>71</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker (ret'd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Fosler</u>				14. MOTHER'S MAIDEN NAME <u>Anna M (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-12-8309</u>		17. INFORMANT <u>William E. Fosler, Jr., 3503 3rd St, ZONE 25</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>200.0 Reticular cell sarcoma of lung, lymph nodes, etc.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>0</u> p. m. <u>0</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 23, 1958</u> to <u>Jan 25, 1958</u> , that I last saw the deceased alive on <u>Jan 25, 1958</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert Mazer</u> M.D. <u>5716 Beechdale Ave</u>				DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>ROBERT MAZER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>3310 Taylor Avenue</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>JAN 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILE NO.

DATE OF DEATH

AGE

NAME OF DECEASED

SEX

RACE

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

NAME OF FUNERAL HOME

ADDRESS OF FUNERAL HOME

NAME OF MINISTER

ADDRESS OF MINISTER

NAME OF CHURCH

ADDRESS OF CHURCH

NAME OF CEMETERY

ADDRESS OF CEMETERY

NAME OF INTERVIEWER

ADDRESS OF INTERVIEWER

NAME OF WITNESS

ADDRESS OF WITNESS

NAME OF SIGNER

ADDRESS OF SIGNER

NAME OF REGISTRAR

ADDRESS OF REGISTRAR

NAME OF CLERK

ADDRESS OF CLERK

NAME OF CHIEF CLERK

ADDRESS OF CHIEF CLERK

NAME OF ASSISTANT CLERK

ADDRESS OF ASSISTANT CLERK

NAME OF DEPUTY CLERK

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NAME OF CLERK

ADDRESS OF CLERK

BUREAU V. S.

JAN 28 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

278

CERTIFICATE OF DEATH

00263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>6 mo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>235 Bloomsbury Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Aleyna</i> Middle <i>Foster</i> Last <i>Foster</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>26</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 14, 1937</i> 9. AGE (In years last birthday) <i>20</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Bierley</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Leister</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Mr. John C. Foster</i>	
17. INFORMANT <i>235 Bloomsbury Ave</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Decompensation</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Auricular Fibrillation</i> DUE TO (c) <i>Chronic Hypertensive Cardis-Vascular Disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>1 year</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-30</i> , 1957, to <i>1-26</i> , 1958, that I last saw the deceased alive on <i>1-25</i> , 1958, and that death occurred at <i>2:30</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i>		ADDRESS (Street, city or town, state) <i>6209 Frederick Ave. Baltimore-25, Md.</i>	
DATE SIGNED <i>1-27-58</i>			
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 28, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Havre de Grace, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madison Mitchell</i>		ADDRESS <i>Havre de Grace Md</i>	
24a. REC'D BY REGISTRAR <i>JAN 30 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. Hedden</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES H. HARRIS		65		M		W		1873		BALTIMORE		BALTIMORE		MD		USA		JAN 30 1938		BALTIMORE		BALTIMORE		MD		USA	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MARITAL STATUS		MOTHER'S MARITAL STATUS		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH	
JAMES H. HARRIS		JANE H. HARRIS		Carpenter		Homemaker		High School		High School		Roman Catholic		Roman Catholic		Married		Married									
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVAILING DISEASE		PREVAILING SYMPTOMS		PREVAILING SIGNS		PREVAILING TREATMENT		PREVAILING NUTRITION		PREVAILING HYGIENE		PREVAILING CLIMATE		PREVAILING SEASON		PREVAILING TIME OF DAY		PREVAILING TIME OF YEAR		PREVAILING TIME OF MONTH	
Heart Failure		Natural		Several Weeks		Coronary Artery Disease		Chest Pain		Shortness of Breath		Medication		Diet		Cleanliness		Weather		Winter		Evening		January		1938	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

JAN 30 1938

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

Item 20b Film 224 1-17-58  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00264

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix, (Rural)</b> c. LENGTH OF STAY IN lb <b>none</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparks, (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Jarrettsville Rd., Sunnybrook</b>		d. STREET ADDRESS <b>Glencoe Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Levering Foster</b>		4. DATE OF DEATH Month <b>1-4</b> Day <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-30-1936</b>
9. AGE (in years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tool mfg.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>E. Levering Foster</b>		14. MOTHER'S MAIDEN NAME <b>Jeannette Kraus</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-30-7317</b>	
17. INFORMANT <b>E. Levering Foster</b>		Address <b>Sparks, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing &amp; Penetrating Injury to Chest - Fractured Neck - Multiple Other Fractures</b> 823 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto left road and ran down embankment completely demolishing auto, crushing driver inside.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. # 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) #		20f. (City or town) # (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-7-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Jessops Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Sparks, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Scott Brooks</b>		24a. REC'D BY REGISTRAR <b>1/6/58</b>	
ADDRESS <b>622 York Rd., Towson 4, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

MEDICAL CERTIFICATION

03

2

JAN 9 '58

FOR STATE  
HEALTH DEPT.

State of Maryland  
Baltimore

Resident, (Mort.)  
Baltimore

Apprentice No. 1, Baltimore

On the 1st day of January, 1938

White

Inspector

Laverne Foster

do

850-10-1315

Evening paper, Sparks, Md.

*[Faint, illegible text, possibly a signature or address]*

*[Faint, illegible text, possibly a signature or address]*

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JAN 9 1938

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1-7-38

602 York St., Towson, Md.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

280

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1209 Eastern Ave.</u>		e. STREET ADDRESS <u>1209 Eastern Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine M. Fox</u>		4. DATE OF DEATH <u>Jan. 12, 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Benjamin Firoved</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Klein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. John R. Dorsey</u>		Address <u>1209 Eastern Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Cardio-Vascular</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7</u> —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Jan. 16, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Woodsboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		24a. REC'D BY REGISTRAR <u>16 '58</u>	
ADDRESS <u>7401 Belair Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Couch</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 16 1938

BUREAU V. 3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
RESIDENCE: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

## 281 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>	c. LENGTH OF STAY IN 1b <u>life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Paper Mill Rd.</u>		d. STREET ADDRESS <u>Paper Mill Rd</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Doris Wilson Freeland</u>		4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-1927</u>
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Harry Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Anna Hoffman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-26-8917</u>	
17. INFORMANT <u>Charence E. Freeland, Jr., Phoenix, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crushing Injury of Skull</u> <u>976x</u> DUE TO <u>from gunshot wound in mouth</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-13-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>		24a. REC'D BY REGISTRAR <u>622 York Rd., Towson 4, Md.</u>	
		24b. REGISTRAR'S SIGNATURE <u>DATE JAN 13 1958</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 13 1952

282  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>147 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>24 S. Kresson Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VESTER</b> Middle <b>E.</b> Last <b>GAMBLE</b>		4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1900</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Order Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Groceries Nonongalia Co. W. Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ira W. Gamble</b>		14. MOTHER'S MAIDEN NAME <b>Minerva Runner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>216-10-4539</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>August 27, 1957</b> , to <b>January 21, 1958</b> , and that death occurred at <b>1:25 A. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chien Wei Lan</b>		DATE SIGNED <b>VA HOSPITAL, FT. HOWARD, MARYLAND 1/21/58</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-24-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Zeiler</b>		24a. REC'D BY REGISTRAR <b>24 '58</b>	
ADDRESS <b>6804 Eastern Ave., Baltimore, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Deed</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





283

## CERTIFICATE OF DEATH

00268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>		c. LENGTH OF STAY IN 1b <b>64 YRS. 11 MO.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROSEWOOD STATE TRAINING SCHOOL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANGELO</b> Middle <b>CHARLES</b> Last <b>GARCIA</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 19, 1947</b>
9. AGE (In years last birthday) <b>10</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANGELO GARCIA</b>		14. MOTHER'S MAIDEN NAME <b>JUANITA LOCKE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>ROSEWOOD RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> <b>193.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Left hemispherectomy of brain, 3 years old</b> DUE TO (c) <b>Former astrocytoma left hemisphere</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>490x</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>12:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Rich. Lindenberg (Pathologist)</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Rich. Lindenberg (Pathologist)</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JAN 23 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Owings Mills Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Elmer Sons Rustatorium</b>		24a. REC'D BY REGISTRAR <b>JAN 24 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG225 2-7-58 et

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice, Towson-4 Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>8113 Hillendale Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>May</b> Last <b>Garrison</b>				4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/22/1878</b>		9. AGE (In years last birthday) <b>79 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Larduskey</b>				14. MOTHER'S MAIDEN NAME <b>Mary Mead</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Admission Record</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 442x DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Hypertensive Cardio Renal</b> DUE TO (c) <b>Vascular Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 29, 1958</b> to <b>January 31, 1958</b> , that I last saw the deceased alive on <b>January 30, 1958</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.				ADDRESS (Street, city or town, state) <b>501 York Rd. Towson 4 Md.</b>		DATE SIGNED <b>1/31/58</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell MD</b>				Towson 4 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 4, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Dunn Sons</b>				ADDRESS <b>Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 3 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Quinn</b>			

**BUREAU V. S.**

FEB 3 1958

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285

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD MARYLAND</b>				c. LENGTH OF STAY IN 1b <b>12 DAYS</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				d. STREET ADDRESS <b>3120 ST PAUL STREET</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>S</b> Last <b>GEORGE</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>12</b> Year <b>19 58</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 5, 1888</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HELPER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BEAUTY SHOP</b>		11. BIRTHPLACE (State or foreign country) <b>PALESTINE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>SIMON GEORGE</b>				14. MOTHER'S MAIDEN NAME <b>HESHMEH AZAR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>YES WW-1</b>				16. SOCIAL SECURITY NO. <b>220-18-69</b>		17. INFORMANT <b>CLIN REC VET ADM HOSP FORT HOWARD MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA ; PULMONARY CONGESTION AND EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>UNKNOWN EDE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>DECEMBER 31, 19 57</b> , to <b>JANUARY 12, 19 58</b> , and that death occurred at <b>11:30 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>1/13/58</b>							
ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> 1/13/58							
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1-16-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc</b>				ADDRESS <b>6009 Harford Rd, Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Chien Wei Lan</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU**

JAN 21 1958

RECEIVED



286

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) o. STATE <u>Md</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>3701.4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>				d. STREET ADDRESS <u>3930 Bedardale Rd</u>			
3. NAME OF DECEASED (Type or print) <u>ISIDOR</u> First <u>GIBBER</u> Middle <u></u> Last				4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Benjamin</u>				14. MOTHER'S MAIDEN NAME <u>Sarah</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>218-32-0703</u>		17. INFORMANT <u>Kelia Giller</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Hypertensive Cardiovascular Disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 da.</u> <u>1037. (2)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>12-31</u> , 19 <u>57</u> , to <u>1-4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-4</u> , 19 <u>58</u> , and that death occurred at <u>12:35 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D. <u>6209 Frederick Ave.</u>				<u>1-4-58</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				<u>Baltimore 28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young men</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eutaw Place</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 7 1959

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

00272

287

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Franklintown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Franklintown</b>			
c. LENGTH OF STAY IN 1b <b>25 Yrs.</b>				d. STREET ADDRESS <b>5203 Pleasant St.,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5203 Pleasant St.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Ellsworth</b> Last <b>Gillespie</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>5</b> Year <b>19 58.</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 25, 1878</b>	
9. AGE (In years last birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Lorraine Cemetery</b>			
13. FATHER'S NAME <b>George Gillespie</b>				14. MOTHER'S MAIDEN NAME <b>Alice Getty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Alice G. Gillespie 5203 Pleasant St.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>501x Coronary Occlusion</b> DUE TO (b) <b>Branches</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Malnutrition</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr - 2 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 1940</b> to <b>Jan 5, 1958</b> , that I last saw the deceased alive on <b>Jan 4, 1958</b> , and that death occurred at <b>5 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thos. G. Abbott</b>				DATE SIGNED <b>1-7-58</b>			
PHYSICIAN'S NAME (Type) <b>Thos. G. Abbott</b>				ADDRESS (Street, city or town, state) <b>4509 Liberty Hwy, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-8-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. Howard Strong</b>				24a. REC'D BY REGISTRAR <b>3207 W. North Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>DATE JAN 8 1958</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration or prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

00273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>				d. STREET ADDRESS <b>7902 Knollwood Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>GILLOW</b> Last <b>JOSEPH E. GILLOW</b>				4. DATE OF DEATH Month <b>January</b> Day <b>27</b> , Year <b>1958</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 23, 1872</b>		9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Builder-retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>				11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Gillow</b>				14. MOTHER'S MAIDEN NAME <b>Mary Carlisle</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>Span-Amer.</b>		17. INFORMANT Address <b>Mrs. Gladys Clark, Towson, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>Pneumonia left lower lung</b>								INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>493X</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>SEPT 1957</b> to <b>JAN 27 1958</b> , that I last saw the deceased alive on <b>JAN 23 1958</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>17 W. PENNA. AVE. TOWSON 4, Md.</b> DATE SIGNED <b>JAN 27, 1958</b> ACTUAL SIGNATURE <b>T. C. Siwinski</b> M.D. PHYSICIAN'S NAME (Type) <b>T. C. SIWINSKI</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>Jan. 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>W.F.Heyer Funeral Home</b>		22d. LOCATION (City, town, or county) (State) <b>Heightstown, N.J.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Md.</b>						24a. REC'D BY REGISTRAR DATE <b>JAN 29 58</b>		24b. REGISTRAR'S SIGNATURE <b>Ch. Beach</b>			







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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>				c. LENGTH OF STAY IN 1b <i>52</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>116 S. Prospect Ave</i>				d. STREET ADDRESS <i>116 S. Prospect Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Isabelle May Glayebrook</i>				4. DATE OF DEATH Month Day Year <i>11/16/58</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/5/1877</i>	
9. AGE (In years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>✓ ?</i>				14. MOTHER'S MAIDEN NAME <i>✓ ?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Clyde B. Glayebrook</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMATA UTERUS</i> <i>174X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>0</i>							
20c. TIME OF INJURY Hour a. m. p. m. <i>0 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>0</i>		20f. (City or town) (County) (State) <i>0</i>	
21. I certify that I attended the deceased from <i>53</i> , to <i>JAN, 16, 1958</i> , that I last saw the deceased alive on <i>JAN, 15, 1958</i> , and that death occurred at <i>9:4 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>6348 FREDERICK ROAD.</i>							
ACTUAL SIGNATURE <i>S. Lloyd Johnson</i> M.D.				6348 FREDERICK ROAD. CATONSVILLE			
PHYSICIAN'S NAME (Type) <i>S. LLOYD JOHNSON, M.D.</i>				6348 FREDERICK ROAD. CATONSVILLE			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/20/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Johnson</i> ADDRESS <i>28</i>				24a. REC'D BY REGISTRAR DATE <i>JAN 21 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. Johnson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
OCCUPATION		EDUCATION		MARRIAGE	
DATE OF DEATH		PLACE OF DEATH		CITY	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE	
DATE OF FILING		FILER		OFFICE	

CARCINOMATA UTERUS

RECEIVED  
JAN 21 1938  
BUREAU V. A.

6348 FREDERICK ROAD.

6348 FREDERICK ROAD.

S. LLOYD JOHNSON, M.D.

JAN 15 1938

290

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rogers Forge</b>				c. LENGTH OF STAY IN 1b <b>2 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7102 Heathfield Road</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rogers Forge</b>			
f. STREET ADDRESS <b>7102 Heathfield Rd.</b>				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>HENRY</b> Last <b>GOOD</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>17</b> Year <b>1958</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/18/76 9/3/76 81</b>	
9. AGE (In years last birthday) <b>81</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret. Police Department</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Good</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Coan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>Mildred Williams, dght., above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>canceroma of bladder</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cerebral sclerosis, emphysema, chronic bronchitis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Jan 15, 1958</b> to <b>Jan 17, 1958</b> that I last saw the deceased alive on <b>Jan 17, 1958</b> and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>William F. Renner</b> M.D. <b>11 W. 29th St. Balt. 18</b> PHYSICIAN'S NAME (Type) <b>William F. RENNER, 11 W. 29th St. Balt. 18</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/21/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b> <b>3331 Brehms Lane</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 21 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. F. Renner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**BUREAU V. S.**

JAN 21 1958

REGELVEL

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3934 Benson Ave</b>		d. STREET ADDRESS <b>3934 Benson Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Amelia L. Greenhood</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>13</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Schuhert</b>		14. MOTHER'S MAIDEN NAME <b>Margaret -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Arthur Williams. 3934 Benson Ave Halethorpe</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Geo. S. M. Kieffer</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED <b>Jan. 13, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/16/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lohrner &amp; Sons - Balto.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 17 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Red Leach</b>	

IAN 20 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00277

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balto.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville &amp;</u> c. LENGTH OF STAY IN 1b <u>4 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7910 Seven Mile Lane</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Harrison, md.</u> d. STREET ADDRESS <u>1 Green Lea</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ALVIN</u> Middle <u>GREIF</u> Last <u>jr.</u>		<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>5</u> Year <u>1958</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Apr 24, 1914</u>		
<b>9. AGE</b> (In years last birthday) <u>43</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clothing manufacturer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>clothing</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Balto. md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Alvin Greif Sr.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Flora Beckhofer</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1942</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-01-3332</u>			
<b>17. INFORMANT</b> <u>Leonard L. Greif Jr.</u>		<b>Address</b> <u>  </u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>acute coronary occlusion</u>  <u>420.1</u> DUE TO  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b)</b> <u>Hypertensive C.V. Disease</u>  <b>DUE TO</b>  <b>(c)</b> <u>  </u> </td> <td style="width: 20%; vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>15 min.</u>  <u>3 yrs.</u> </td> </tr> </table> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>none</u>				<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>acute coronary occlusion</u> <u>420.1</u> DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Hypertensive C.V. Disease</u> <b>DUE TO</b> <b>(c)</b> <u>  </u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>15 min.</u> <u>3 yrs.</u>
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>acute coronary occlusion</u> <u>420.1</u> DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Hypertensive C.V. Disease</u> <b>DUE TO</b> <b>(c)</b> <u>  </u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>15 min.</u> <u>3 yrs.</u>				
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <u>none</u>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>was taken to retrosternal discomfort &amp; dyspnea.</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>none</u> 19 <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>none</u>		<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
<b>ACTUAL SIGNATURE</b> <u>D.D. Caples</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>D.D. CAPLES</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>1-5-58</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>1/7/58</u>			
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore Hebrew</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Balto., Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Lieber &amp; Sons Balto 17nd</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>JAN 10 58</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>		<b>24c. REGISTRAR'S SIGNATURE</b> <u>  </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. MANNER OF DEATH		11. SIGNATURE OF MEDICAL EXAMINER		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF DEPUTY SHERIFF	
19. SIGNATURE OF JAILER		20. SIGNATURE OF WARDEN		21. SIGNATURE OF DEPUTY WARDEN	
22. SIGNATURE OF CHIEF CLERK		23. SIGNATURE OF CHIEF DEPUTY CLERK		24. SIGNATURE OF CHIEF DEPUTY CLERK	
25. SIGNATURE OF CHIEF DEPUTY CLERK		26. SIGNATURE OF CHIEF DEPUTY CLERK		27. SIGNATURE OF CHIEF DEPUTY CLERK	
28. SIGNATURE OF CHIEF DEPUTY CLERK		29. SIGNATURE OF CHIEF DEPUTY CLERK		30. SIGNATURE OF CHIEF DEPUTY CLERK	
31. SIGNATURE OF CHIEF DEPUTY CLERK		32. SIGNATURE OF CHIEF DEPUTY CLERK		33. SIGNATURE OF CHIEF DEPUTY CLERK	
34. SIGNATURE OF CHIEF DEPUTY CLERK		35. SIGNATURE OF CHIEF DEPUTY CLERK		36. SIGNATURE OF CHIEF DEPUTY CLERK	
37. SIGNATURE OF CHIEF DEPUTY CLERK		38. SIGNATURE OF CHIEF DEPUTY CLERK		39. SIGNATURE OF CHIEF DEPUTY CLERK	
40. SIGNATURE OF CHIEF DEPUTY CLERK		41. SIGNATURE OF CHIEF DEPUTY CLERK		42. SIGNATURE OF CHIEF DEPUTY CLERK	
43. SIGNATURE OF CHIEF DEPUTY CLERK		44. SIGNATURE OF CHIEF DEPUTY CLERK		45. SIGNATURE OF CHIEF DEPUTY CLERK	
46. SIGNATURE OF CHIEF DEPUTY CLERK		47. SIGNATURE OF CHIEF DEPUTY CLERK		48. SIGNATURE OF CHIEF DEPUTY CLERK	
49. SIGNATURE OF CHIEF DEPUTY CLERK		50. SIGNATURE OF CHIEF DEPUTY CLERK		51. SIGNATURE OF CHIEF DEPUTY CLERK	
52. SIGNATURE OF CHIEF DEPUTY CLERK		53. SIGNATURE OF CHIEF DEPUTY CLERK		54. SIGNATURE OF CHIEF DEPUTY CLERK	
55. SIGNATURE OF CHIEF DEPUTY CLERK		56. SIGNATURE OF CHIEF DEPUTY CLERK		57. SIGNATURE OF CHIEF DEPUTY CLERK	
58. SIGNATURE OF CHIEF DEPUTY CLERK		59. SIGNATURE OF CHIEF DEPUTY CLERK		60. SIGNATURE OF CHIEF DEPUTY CLERK	
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64. SIGNATURE OF CHIEF DEPUTY CLERK		65. SIGNATURE OF CHIEF DEPUTY CLERK		66. SIGNATURE OF CHIEF DEPUTY CLERK	
67. SIGNATURE OF CHIEF DEPUTY CLERK		68. SIGNATURE OF CHIEF DEPUTY CLERK		69. SIGNATURE OF CHIEF DEPUTY CLERK	
70. SIGNATURE OF CHIEF DEPUTY CLERK		71. SIGNATURE OF CHIEF DEPUTY CLERK		72. SIGNATURE OF CHIEF DEPUTY CLERK	
73. SIGNATURE OF CHIEF DEPUTY CLERK		74. SIGNATURE OF CHIEF DEPUTY CLERK		75. SIGNATURE OF CHIEF DEPUTY CLERK	
76. SIGNATURE OF CHIEF DEPUTY CLERK		77. SIGNATURE OF CHIEF DEPUTY CLERK		78. SIGNATURE OF CHIEF DEPUTY CLERK	
79. SIGNATURE OF CHIEF DEPUTY CLERK		80. SIGNATURE OF CHIEF DEPUTY CLERK		81. SIGNATURE OF CHIEF DEPUTY CLERK	
82. SIGNATURE OF CHIEF DEPUTY CLERK		83. SIGNATURE OF CHIEF DEPUTY CLERK		84. SIGNATURE OF CHIEF DEPUTY CLERK	
85. SIGNATURE OF CHIEF DEPUTY CLERK		86. SIGNATURE OF CHIEF DEPUTY CLERK		87. SIGNATURE OF CHIEF DEPUTY CLERK	
88. SIGNATURE OF CHIEF DEPUTY CLERK		89. SIGNATURE OF CHIEF DEPUTY CLERK		90. SIGNATURE OF CHIEF DEPUTY CLERK	
91. SIGNATURE OF CHIEF DEPUTY CLERK		92. SIGNATURE OF CHIEF DEPUTY CLERK		93. SIGNATURE OF CHIEF DEPUTY CLERK	
94. SIGNATURE OF CHIEF DEPUTY CLERK		95. SIGNATURE OF CHIEF DEPUTY CLERK		96. SIGNATURE OF CHIEF DEPUTY CLERK	
97. SIGNATURE OF CHIEF DEPUTY CLERK		98. SIGNATURE OF CHIEF DEPUTY CLERK		99. SIGNATURE OF CHIEF DEPUTY CLERK	
100. SIGNATURE OF CHIEF DEPUTY CLERK		101. SIGNATURE OF CHIEF DEPUTY CLERK		102. SIGNATURE OF CHIEF DEPUTY CLERK	

BUREAU V. S.

JAN 18 1953

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - OWINGS MILLS</u>		c. LENGTH OF STAY IN 1b <u>15 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS - MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>WARDS CHAPEL RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANE</u> Last <u>GRAVES</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 1-1866</u>	9. AGE (In years lost birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME-KEEPING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FIRST NAME UNKNOWN - TRIPETT</u>				14. MOTHER'S MAIDEN NAME <u>CHARA JEAN BARNES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS WALTER GREIS - WARDS CHAPEL RD OWINGS MILLS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY EDEMA &amp; KIDNEY FAILURE</u> DUE TO (c) <u>HYPERTENSIVE C.O. DISEASE; GENERAL</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>15 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROSIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct - 15</u> , 19 <u>57</u> , to <u>JAN 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN 23</u> , 19 <u>58</u> , and that death occurred at <u>7 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>				ADDRESS (Street, city or town, state) <u>RANDAKSTOWN - MD</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>				DATE SIGNED <u>1/23/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-25-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WARDS CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Haight</u>				ADDRESS <u>Crydonville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. L. Leach</u>			



00279

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

293

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 9 Film G225 1-31-58 et

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fullerton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7305 Linden ave overlea</u>		MARYLAND LENGTH OF STAY (in this place) <u>20 yrs</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Overlea - md.</u> STREET ADDRESS (If rural, give location) <u>7305 Linden Ave Overlea</u>	
3. NAME OF DECEASED (Type or Print) <u>Walter A. Griffin</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>12</u> (Year) <u>1958</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>WIDOWED</u>		8. DATE OF BIRTH <u>8/18-1896</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>67</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>William Griffin</u>	
14. MOTHER'S MAIDEN NAME <u>Harriet Hamilton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1918</u>		16. SOCIAL SECURITY NO. <u>215-01-2723A</u>	
17. INFORMANT AND ADDRESS <u>Walter Nelson 15427 Wolff St</u>					

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X Immediate cause (a) lung cancer

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH  
3 yrs?II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 11-1-, 1957, to 1-12, 1958, that I last saw the deceased alive on 1-12, 1958, and that death occurred at 11 a. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. Richard A. Sigler

M.D.

1 W. Overlea Ave.

1-13-58

23. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-16-58</u>		NAME OF CEMETERY OR CREMATORY <u>U.S. Balto National</u>		LOCATION (City, town, or county) <u>Balto</u>		(State) <u>md.</u>
DATE REC'D BY LOCAL REG. <u>1/15/58</u>		REGISTRAR'S SIGNATURE <u>A.W. Hedrich</u>		24. FUNERAL DIRECTOR <u>Rayner Sanders</u>		ADDRESS <u>217 E. Preston St</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
JAN 17 1958  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00280

294

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chattalane</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chattalane, Baltimore County</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Richard Hugh Swathney</i>		4. DATE OF DEATH Month <i>January</i> Day <i>19</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 7, 1881</i>
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Oversaw (Private Estg)</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>King &amp; Queen Co., Virginia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Robert Swathney</i>		14. MOTHER'S MAIDEN NAME <i>Alice Robinson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Alice Pinderhugh</i>		Address <i>2520 Harlem Ave. S.W. Balt.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral Hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c) <i>arterio-sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>10 yrs.</i> <i>20 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/2</i> , 19 <i>56</i> , to <i>Jan 19</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Jan 18</i> , 19 <i>58</i> , and that death occurred at <i>9 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Palmer F.C. Williams</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>1/20/58</i>	
PHYSICIAN'S NAME (Type) <i>Palmer F.C. Williams</i>		<i>P. Kenville S. M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan 22, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Thomas Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Garrison, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph L. Rues</i>		24. REC'D BY REGISTRAR DATE <i>JAN 23 '58</i>	
ADDRESS <i>2222 W. North Ave. Balt.</i>		24b. REGISTRAR'S SIGNATURE <i>Quint</i>	

JAN 23 1959

RECEIVED

## CERTIFICATE OF DEATH

00281

Reg. Dist. No.

295

1. PLACE OF DEATH o. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Freeland (Freeland)</i>	c. LENGTH OF STAY IN 1b <i>4-5 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Freeland (rural)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ruhl Road</i>		d. STREET ADDRESS <i>Ruhl Road</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>A</i> Last <i>Hackett</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>29</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 5, 1875</i>
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Crest Barthol</i>	
14. MOTHER'S MAIDEN NAME <i>Christine Burgadine</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lillian Roth - daughter</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Senility</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept.</i> , 19 <i>54</i> , to <i>Jan.</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Jan. 28</i> , 19 <i>58</i> , and that death occurred at <i>12:30</i> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>New Freedom, Pa.</i> DATE SIGNED <i>Richard Robinson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>			
22b. DATE THEREOF <i>2-1-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>MORELAND PK.</i>	
22d. LOCATION (City, town, or county) (State) <i>BALTO Md.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>	
24a. REC'D BY REGISTRAR DATE <i>JAN 31 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. PLACE OF DEATH: [illegible]  
9. DATE OF DEATH: [illegible]  
10. SIGNATURE OF PHYSICIAN: [illegible]  
11. SIGNATURE OF REGISTRAR: [illegible]  
12. SIGNATURE OF WITNESS: [illegible]

BUREAU Y. 8

JAN 31 1958

RECEIVED

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

296

Item 7 File No. 225 1-31-58 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

00282

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>55 Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8812 Eddington Road</i>		d. STREET ADDRESS <i>18812 Eddington Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Mary Jane Hagerty</i>		4. DATE OF DEATH Month Day Year <i>January 25 19 58</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Separated</i>	8. DATE OF BIRTH <i>Feb. 10, 1888</i>
9. AGE (In years last birthday) <i>69</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Cecil Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Blanchfield</i>		14. MOTHER'S MAIDEN NAME <i>Martha Schelton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Joseph Fratantuono</i>		Address <i>8812 Eddington</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Atherosclerosis</i> DUE TO <i>+ Coronary Sclerosis</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Old Cerebral Vascular accident</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 1957</i> to <i>Jan 25, 1958</i> , that I last saw the deceased alive on <i>Dec 27, 1957</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph F. Li Pira</i> M.D.		ADDRESS (Street, city or town, state) <i>8400 Loch Raven Blvd.</i>	
DATE SIGNED <i>1/25/58</i>			
PHYSICIAN'S NAME (Type) <i>Joseph F. Li Pira</i>		<i>Baltimore, 4, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-28-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bethel Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Cecil County, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>JAN 28 1958</i>		24b. REGISTRAR'S SIGNATURE <i>ASST. REGISTRAR</i>	







1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

297

## CERTIFICATE OF DEATH

00283

Item 1 FilmG224 1-15-58 et

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		CITY <u>BALTIMORE</u>		TOWN <u>3001.4</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>CATONSVILLE</u>		<u>1 month</u>		STREET ADDRESS <u>3037 FREDERICK AVE.</u>		RURAL (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Forest Haven</u>				STREET ADDRESS <u>3037 FREDERICK AVE.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>MARY FLORENCE HALL</u>				<u>JAN. 8, 1958</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>white</u>	<u>WIDOWED</u>	<u>MAY 11, 1869</u>	<u>88</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Domestic</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL Souder</u>				14. MOTHER'S MAIDEN NAME <u>KEZIAH Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>VIOLA SNOW 3037 Frederick Ave.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							<b>INTERVAL BETWEEN ONSET AND DEATH</b>
18. MEDICAL CERTIFICATION							
422.1 IMMEDIATE CAUSE (A) <u>ARTERIO SCLEROTIC CARDIAC</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIAL DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>PNEUMONITIS</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/1</u> , 19 <u>57</u> to <u>1/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/8</u> , 19 <u>58</u> , and that death occurred at <u>4:00</u> M. from the causes and on the date stated above.							
SIGNATURE <u>John H. Snow</u>		DATE THEREOF <u>1-10-58</u>		NAME OF CEMETERY OR CREMATORY <u>LONDON PARK BALTIMORE MD.</u>		LOCATION (City, town, or county) (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-10-58</u>		NAME OF CEMETERY OR CREMATORY <u>LONDON PARK BALTIMORE MD.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. School</u>		ADDRESS <u>2101 Maryland Ave Baltimore, Md.</u>	
DATE <u>JAN 10 1958</u>							



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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>				c. LENGTH OF STAY IN 1b <b>1½ yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15 Lan Lea Drive</b>				d. STREET ADDRESS <b>15 Lan Lea Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Rae</b> Middle <b>Samuel</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>1-28</b> Day <b>19</b> Year <b>58</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-26-1895</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min.		IF UNDER 24 HRS. Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Industrial Engineer Radio Mfg.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mass.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander Hall</b>				14. MOTHER'S MAIDEN NAME <b>Grace Chapman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW I</b>				16. SOCIAL SECURITY NO. <b>034-07-3759</b>			
17. INFORMANT <b>Belle N. Hall, 15 Lan Lea Dr., Lutherville</b>				Address <b>Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Infarction</b> DUE TO (c) <b>Hypertensive C-V disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks</b> <b>7 weeks</b> <b>10 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 1952</b> to <b>Jan-28, 1958</b> , that I last saw the deceased alive on <b>Jan-28, 1958</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>200 W. Penn. Ave. Towson 4 Md.</b> DATE SIGNED <b>1/29/58</b>							
ACTUAL SIGNATURE <b>Tom A. Sedlack</b>				PHYSICIAN'S NAME (Type) <b>Tom A. Sedlack</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				22b. DATE THEREOF <b>1-31-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>L Scott Brooks</b>				ADDRESS <b>622 York Rd., Towson 4, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 31 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL OF DRAIN

Bellevue

Bellevue

Bellevue

Bellevue

12 yrs.

Bellevue

12 Jan Jan Drive

12 Jan Jan Drive

1-25

Samuel Hall

Samuel Hall

12-30-1972

white

white

Industrial Engineer Radio Mfg.

James Hall

James Hall

024-07-0752 Bell

024-07-0752 Bell

024-07-0752 Bell

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JAN 31 1958

RECEIVED

Green Mount

1-31-58

622 York Rd., Towson, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration information prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00285

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>1958</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <b>July 25, 1910</b>		9. AGE (In years last birthday) <b>47</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas James Hamilton</b>		14. MOTHER'S MAIDEN NAME <b>Alice Doxen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>216-03-4360</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL EDEMA AND CONGESTION</b> <b>581.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>FATTY CHANGES OF LIVER</b> DUE TO <b>ALCOHOLISM</b> (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Cellulitis, left leg. 2. Chronic granulomatous lesion, right upper lung.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>January 10, 1958</b> , to <b>January 14, 1958</b> , <b>6:30 A. M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>Chui K. Jaw</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>		<b>1/14/58</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-17-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd. Balto. 14, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Wm. Cook-Blight</b>			



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		45		JAN 15 1913		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES OF AMERICA	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL OCCUPATION		MILITARY SERVICE	
White		White		Roman Catholic		Married		High School		Carpenter		None		None	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
JAN 21 1958		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES OF AMERICA		HEART DISEASE		Natural		JAMES H. HARRIS	
DATE OF REPORT		PLACE OF REPORT		CITY OF REPORT		STATE OF REPORT		COUNTRY OF REPORT		REPORTER		SIGNATURE		TITLE	
JAN 21 1958		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES OF AMERICA		JAMES H. HARRIS		JAMES H. HARRIS		Physician	

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JAN 21 1958

RECEIVED



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>51</u> <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN 1b <u>51</u> <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5720 Oakland Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Agnes</u> Last <u>Harrah</u>				4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 25, 1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Amherst, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Danehy</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Mrs. Eileen Walsh</u>		Address <u>5720 Oakland Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>443X</u> DUE TO <u>arteriosclerosis, generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u> <u>5+ years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1952</u> , to <u>Jan. 3, 1958</u> , that I last saw the deceased alive on <u>2-1 Dec. 1957</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis P. Hamburger Jr.</u>				M.D. <u>1001 St. Paul St. Baltor Md 3 Jan 1958</u>			
PHYSICIAN'S NAME (Type) <u>Louis P. Hamburger Jr.</u>				<u>1001 St. Paul Street</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Jan. 4, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>North Hampton Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u>				ADDRESS <u>1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>JAN 6 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>R. M. M. M. M.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>		4. DATE OF BIRTH <b>1880</b>		5. PLACE OF BIRTH <b>MASSACHUSETTS</b>	
6. OCCUPATION <b>LABORER</b>		7. CAUSE OF DEATH <b>HEART DISEASE</b>		8. MANNER OF DEATH <b>NATURAL</b>		9. DATE OF DEATH <b>JAN 10 1925</b>		10. PLACE OF DEATH <b>HOME</b>	
11. SIGNATURE OF PHYSICIAN <b>DR. J. J. BROWN</b>		12. SIGNATURE OF REGISTRAR <b>JOHN J. BROWN</b>		13. SIGNATURE OF DECEASED <b>JOHN J. BROWN</b>		14. SIGNATURE OF WITNESSES <b>JOHN J. BROWN</b>		15. SIGNATURE OF CLERK <b>JOHN J. BROWN</b>	
16. NAME OF DECEASED <b>JOHN J. BROWN</b>		17. SEX <b>MALE</b>		18. AGE <b>45</b>		19. DATE OF BIRTH <b>1880</b>		20. PLACE OF BIRTH <b>MASSACHUSETTS</b>	
21. OCCUPATION <b>LABORER</b>		22. CAUSE OF DEATH <b>HEART DISEASE</b>		23. MANNER OF DEATH <b>NATURAL</b>		24. DATE OF DEATH <b>JAN 10 1925</b>		25. PLACE OF DEATH <b>HOME</b>	
26. SIGNATURE OF PHYSICIAN <b>DR. J. J. BROWN</b>		27. SIGNATURE OF REGISTRAR <b>JOHN J. BROWN</b>		28. SIGNATURE OF DECEASED <b>JOHN J. BROWN</b>		29. SIGNATURE OF WITNESSES <b>JOHN J. BROWN</b>		30. SIGNATURE OF CLERK <b>JOHN J. BROWN</b>	

BUREAU V. S.

JAN 6 1925

RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>N.E. Glen Burnie 02X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eudowood - Towson 4, Md.</b>		d. STREET ADDRESS <b>624 Balto &amp; Annapolis Blvd</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>J.</b> Last <b>HARRISON</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>31</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1929</b>
9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Amer. ca</b>	
13. FATHER'S NAME <b>RAT Racioppa</b>		14. MOTHER'S MAIDEN NAME <b>Thomas Gennsell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Personal History</b> <b>Hospital Records, Eudowood Sanatorium</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia, Bilateral</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-30</b> , 19 <b>58</b> , to <b>1-31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-31</b> , 19 <b>58</b> , and that death occurred at <b>6:30 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Milton B. Kress</b> M.D.		Eudowood Sanatorium	
PHYSICIAN'S NAME (Type) <b>Milton B. Kress, M.D.</b>		Towson 4, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>2-4-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>See Casey Jerome Howard</b>		24a. REC'D BY REGISTRAR <b>DATE 1-24-58</b>	24b. REGISTRAR'S SIGNATURE <b>Redmond</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB

6361

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00288

301  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>55</b> <b>Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1302 Aintree Rd.</b>				d. STREET ADDRESS <b>1302 Aintree Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>HARTMAN</b> Last <b>HARTMAN</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>8,</b> Year <b>1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 25, 1878</b>	
9. AGE (In years last birthday) <b>79 yrs.</b>		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>		IF UNDER 24 HRS. Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Iowa</b>							
13. FATHER'S NAME <b>Henry J. Braasch</b>				14. MOTHER'S MAIDEN NAME <b>Dorothea Auerbach</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mr. Wm. F. Betz, Jr.</b> Address <b>1302 Aintree Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Acute Cardiac Failure</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 20, 1954</b> to <b>Jan 8, 1958</b> , that I last saw the deceased alive on <b>Jan 8, 1958</b> and that death occurred at <b>1:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6805 York Rd Baltimore 12 Md</b> DATE SIGNED <b>1-9-58</b> ACTUAL SIGNATURE <b>Laurence C. Post</b> M.D. PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Pickney &amp; Sons - Balto 17th</b>				23a. REC'D BY REGISTRAR <b>DATE 1-9-58</b>		23b. REGISTRAR'S SIGNATURE <b>Wm. Beach</b>	

RECEIVED



Item 18 Film 225-2-24-58 and Item 20 Film 225-4-24-58 and		<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>		00289	
<b>302 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>					
Reg. Dist. No.					
1. PLACE OF DEATH <b>Rosewood State Training School</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
a. COUNTY <b>Baltimore</b> MARYLAND			a. STATE <b>Maryland</b> b. COUNTY <b>City Balto.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>		c. LENGTH OF STAY IN lb <b>12 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville, Maryland. 52</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Training School</b>			d. STREET ADDRESS <b>721 Edmondson Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Regina</b> Middle Last <b>Harvey</b>			4. DATE OF DEATH Month <b>1</b> Day <b>23</b> Year <b>19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/28/40</b>	9. AGE (In years last birthday) <b>17</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Marshall Harvey</b>			14. MOTHER'S MAIDEN NAME <b>Olivia Malastesta</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address <b>Rosewood Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pending Cerebral Concussion following bumping of head</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>26 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Microcephalic spastic.</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Patient was a severely retarded microcephalic who frequently banged head on the floor or bed or wall</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>7:30 p. m. 1-22-58 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>RS Tr. School</b>	
				20f. (City or town) (County) (State) <b>Owings Mills Balto. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>D.D. Caples</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/24/58</b>
EXAMINER'S NAME (Type) <b>D.D. Caples, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 27/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cem.</b>	
				22d. LOCATION (City, town, or county) (State) <b>Owings Mills</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Ellis, Smo Rustertown</b>			ADDRESS <b>Rustertown</b>		24a. REC'D BY REGISTRAR <b>JAN 30 58</b> DATE
					24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 30 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00290

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>JOHN</b> Last <b>HAUS</b>		4. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>7</b> Days <b>9</b> Hours <b>19</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gateman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna. Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lawrence J. Haus</b>		14. MOTHER'S MAIDEN NAME <b>Anna Keummert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mildred A. Stigler-2807 Silver Hill Ave.</b>	
17. INFORMANT <b>Mildred A. Stigler-2807 Silver Hill Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>S-fracture of age</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-28-58</b> to <b>1-28-58</b> , that I last saw the deceased alive on <b>1-28-58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>4509 Liberty Heights Ave. Dr. Thomas G. Abbott</b> M.D.		DATE SIGNED <b>1-29-58</b>	
PHYSICIAN'S NAME (Type) <b>Thomas G. Abbott, M.D.</b>		<b>4509 Liberty Heights Avenue</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/31/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S NAME (Type) <b>ELLSWORTH ARMACOST</b>		24a. REC'D BY REGISTRAR <b>30 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arb</b>			

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 30 1958

RECEIVED

304

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film 225 1-30-58 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kenner</u> b. COUNTY <u>Christon</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1646 Missula 8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boothwyn 75 x - 3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baynesville</u>		d. STREET ADDRESS <u>323 A Bethel Road</u>	
3. NAME OF DECEASED (Type or print) <u>Cara M. Hawkins</u>		4. DATE OF DEATH <u>Jan 13 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cit. Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert H. Lilly</u>		14. MOTHER'S MAIDEN NAME <u>Dora E. Coale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>174</u>	
17. INFORMANT <u>Ada R. Runkle</u>		Address <u>1646 Missula Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY Occlusion Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Renal</u> (c) <u>Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>CHARLES F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 14 1958 Rock Run Cn</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Harford Co. Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Bailey</u>		ADDRESS <u>Washington Md</u>	
24a. REC'D BY REGISTRAR <u>W. French</u>		24b. REGISTRAR'S SIGNATURE <u>W. French</u>	
DATE <u>JAN 22 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 28 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

305

## CERTIFICATE OF DEATH

00292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>11 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>R.</b> Last <b>HAWKINS SR.</b>				4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-27-97</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months <b>20</b> Days <b>19</b> Hours <b>58</b>	IF UNDER 24 HRS. Months <b>20</b> Days <b>19</b> Hours <b>58</b>	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES ENGINEER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MAIL ORDER HOUSE</b>		11. BIRTHPLACE (State or foreign country) <b>HINSDALE, ILLINOIS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>GAUIS F. HAWKINS</b>				14. MOTHER'S MAIDEN NAME <b>MYRA BURK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		(If yes, give year or dates of service) <b>WW-1</b>		16. SOCIAL SECURITY NO. <b>215-05-3145</b>		17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY THROMBOSIS</b> DUE TO (c) <b>1 WEEK</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>BALTIMORE</b>				20g. (County) <b>BALTIMORE</b>		20h. (State) <b>MARYLAND</b>	
21. I certify that I attended the deceased from <b>JANUARY 9</b> , 19 <b>57</b> , to <b>JANUARY 20</b> , 19 <b>57</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>1-20-58</b>							
ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>				DATE SIGNED <b>1-20-58</b>			
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>1-20-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 23/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WITZKE FUNERAL DIR. 4101 EDMONDSON AVE</b>				24a. REC'D BY REGISTRAR <b>DATE JAN 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. HARRIS</b>	

Witzke Funeral Director, 4101 Edmondson Ave Baltimore Md



## CERTIFICATE OF DEATH

00293

Reg. Dist. No.

306

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>1 WK.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN THE PINES, 16 FUSTING AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SAMUEL E. HEATON</u>				4. DATE OF DEATH <u>JAN. 16, 1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 7, 1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED AGENT, MET. LIFE INS. CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TENN.</u>		11. BIRTHPLACE (State or foreign country) <u>TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HEATON</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA GREER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>219-23-7399A</u>			
				17. INFORMANT <u>MRS BESSIE HEATON, 103 MALLOW HILL RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Hypertensive Cardiac Vascular Renal Disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 da.</u> <u>15 3/4</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>9-8</u> , 19 <u>49</u> , to <u>1-16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-16</u> , 19 <u>58</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>				ADDRESS (Street, city or town, state) <u>6209 Frederick Rd.</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				DATE SIGNED <u>1/18/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 20, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WOODLAWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE FUNERAL DIR.</u>				ADDRESS <u>4101 EDMONDSON AVE</u>		24a. REC'D BY REGISTRAR <u>20 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Reverend</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

Reg. Dist. No.

PLACE OF DEATH

RESIDENCE

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

TIME OF BURIAL

CAUSE OF BURIAL

PLACE OF INTERMENT

DATE OF INTERMENT

TIME OF INTERMENT

CAUSE OF INTERMENT

PLACE OF CREMATION

DATE OF CREMATION

TIME OF CREMATION

CAUSE OF CREMATION

PLACE OF REINTERMENT

DATE OF REINTERMENT

TIME OF REINTERMENT

CAUSE OF REINTERMENT

PLACE OF REINTERMENT

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CAUSE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

TIME OF REINTERMENT

CAUSE OF REINTERMENT

BUREAU V. S.

JAN 20 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00294

## 307 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 114 Rt. 16 Bird River Rd.</u>		e. STREET ADDRESS <u>Box 114 Rt. 16 Bird River Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Helldorfer</u> Last <u>Fey</u>		4. DATE OF DEATH <u>Jan</u> Month <u>30</u> Day <u>1958</u> Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Co. Highway</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>
13. FATHER'S NAME <u>John P. Helldorfer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs. Pearl B. Helldorfer Box 114 Bird River Rd</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular disease</u> DUE TO (c) <u>1 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1957</u> , to <u>Jan 30, 1958</u> , that I last saw the deceased alive on <u>Jan 29, 1958</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. M. Baumgardner</u> M.D.		ADDRESS (Street, city or town, state) <u>Balto 6 Md</u> DATE SIGNED <u>1/30/58</u>	
PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 3, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cosack Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>	
24a. REC'D BY REGISTRAR <u>FEB 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Edick</u>	







308 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		d. STREET ADDRESS <b>02 x 2</b>	
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Arthur</b> Middle <b>Henson</b> Last		4. DATE OF DEATH <b>Jan. 25</b> 19 <b>58</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-1949</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elijah Henson</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Cook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Hospital Records- Rosewood State Tr. School</b>	
17. INFORMANT <b>Owings Mills, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Epilepsy</b> 352x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Anemia, severe malnutrition, dehydration</b> DUE TO (c) <b>Spastic quadriplegia (cerebral palsy)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 9, 1958</b> to <b>January 25, 1958</b> , that I last saw the deceased alive on <b>January 25, 1958</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Rich. Lindenberg (Pathologist)</b>		ADDRESS (Street, city or town, state) <b>Rosewood St. Tr. School</b>	
PHYSICIAN'S NAME (Type) <b>Rich. Lindenberg (Pathologist)</b>		DATE SIGNED <b>Jan 29 58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-31-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Carver Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Laurel Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Anna, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 29 58</b>	24b. REGISTRAR'S SIGNATURE <b>Over with</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

## CERTIFICATE OF DEATH

BUREAU V. 3

JAN 29 1966

RECEIVED

00296

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2722 1/2 Alden Rd.</b>				d. STREET ADDRESS <b>2722 1/2 Alden Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary A. Hinton</b>		First		Middle		Last			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 24, 1886</b>			
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Mark Casserly</b>				14. MOTHER'S MAIDEN NAME <b>?</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Alfred Cooke, 2722 1/2 Alden Road</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C.V.D.</b> <b>260x</b> (c) <b>Diabetes mellitus</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2-6 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan. 7, 1958</b> to <b>Jan. 10, 1958</b> , that I last saw the deceased alive on <b>Jan. 7, 1958</b> , and that death occurred at <b>7:00</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8100 Harford Rd Baltimore, Md.</b> DATE SIGNED <b>H. A. G. ROTT</b>									
ACTUAL SIGNATURE <b>H. A. G. ROTT</b>		PHYSICIAN'S NAME (Type) <b>H. A. G. ROTT, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/13/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>				ADDRESS <b>5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR <b>JAN 13 '58</b>			
				24b. REGISTRAR'S SIGNATURE <b>Alfred Cooke</b>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

13 JAN 1959

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BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

211

## CERTIFICATE OF DEATH

Reg. Dist. No.

00298

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>508 Gun Rd.</b>				e. STREET ADDRESS <b>508 Gun Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>ROSS</b> Middle <b>STUART</b> Last <b>HOSMER</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>9,</b> Year <b>1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1910</b>	9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Manager (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nat. Boh Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ross Lewis Hosmer</b>				14. MOTHER'S MAIDEN NAME <b>Bessie -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Anna Frances Hosmer - 508 Gun Rd. Relay, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162.1 Bronchogenic Carcinoma</b> DUE TO <b>metastasis to abdomen &amp; brain etc</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial insufficiency</b> DUE TO (c) <b>2 mo</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr 6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Apr 26 1957</b> , to <b>Jan 9, 1958</b> , that I last saw the deceased alive on <b>Jan 8, 1958</b> , and that death occurred at <b>7:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5609 Main St Woodlawn, Md.</b> DATE SIGNED <b>1/9/58</b>							
ACTUAL SIGNATURE <b>B B Brumbaugh</b> M.D.				PHYSICIAN'S NAME (Type) <b>B B Brumbaugh</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. J. T. Tucker &amp; Sons - Balto, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 10 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Quelch</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

JAN 13 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

311

## CERTIFICATE OF DEATH

Reg. Dist. No.

00299

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>H.</b> Last <b>HUGHES, Sr.</b>		4. DATE OF DEATH Month <b>January</b> Day <b>18</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1887</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		9b. AGE (In years last birthday) yrs. <b>70</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Company</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge, Md.</b>	
13. FATHER'S NAME <b>Alexander Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Sarah (Maiden Name Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>212-14-2115</b>	
17. INFORMANT <b>Clin.Rec.Vet.Adm.Hosp. Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY THROMBOSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>January 11, 19 58</b> , to <b>January 18, 19 58</b> , that <b>VA</b> was the deceased's attending physician, and that death occurred at <b>9:15 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chien Wei-Lan</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>1/19/58</b>	
PHYSICIAN'S NAME (Type) <b>Chien Wei LAN, M.D.</b>		<b>VAH, FORT HOWARD, MARYLAND.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-22-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave., Baltimore, Maryland.</b>	
24a. REC'D BY REGISTRAR <b>Charles R. Law</b>		24b. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>	

Charles R. Law 802-04 Madison Ave., Baltimore, Maryland. Contractor

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No. 00300

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>35 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>925 Clark Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>A.</b> Last <b>HURLEY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 29, 1893</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Messenger-Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service Naval Base</b>		11. BIRTHPLACE (State or foreign country) <b>New Church, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William A. Hurley</b>				14. MOTHER'S MAIDEN NAME <b>Lula May Watson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>224-03-6097</b>		17. INFORMANT <b>Clin/Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RIGHT LUNG WITH METASTASES TO</b> <b>RIGHT CHEST WALL, RIGHT RIBS, THORACIC LYMPH</b> Nodes, LEFT ADRENAL AND KIDNEYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>VA</b>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>December 18, 1957</b> , to <b>January 22, 1958</b> and that death occurred at <b>6:20 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>1/22/58</b>							
ACTUAL SIGNATURE <i>Chien Wei Lan</i>				M.D. <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-23-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Nelson Cemetery.</b>		22d. LOCATION (City, town, or county) (State) <b>Rural Pocomoke, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight, Inc</i> <b>Wm Cook-Blight, Inc 6009 Harford Rd Balto 14, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 23 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Attest</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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Item 14, File 224, 1-20-58 et

## CERTIFICATE OF DEATH

00301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNESLIE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x ANNESLIE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6311 SHERWOOD RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>C</u> Last <u>IRELAND</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 31, 1878</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO., MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>JOHN KREPPPEL</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>WHORTON IRELAND</u>		Address <u>6311 SHERWOOD RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>				20g. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>			
21. I certify that I attended the deceased from <u>1935</u> to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>April 13, 1957</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6210 York Rd</u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>A.S. Chalfant</u> M.D. <u>  </u>				PHYSICIAN'S NAME (Type) <u>A.S. CHALFANT</u> <u>Baltimore</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LODON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. JENKINS &amp; SONS</u>				ADDRESS <u>4905 YORK RD</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 14 58</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>				24c. REGISTRAR'S SIGNATURE <u>  </u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1933</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF JURY <i>John Doe</i>	
16. SIGNATURE OF JURY <i>John Doe</i>		17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JURY <i>John Doe</i>	
22. SIGNATURE OF JURY <i>John Doe</i>		23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>		27. SIGNATURE OF JURY <i>John Doe</i>	
28. SIGNATURE OF JURY <i>John Doe</i>		29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>		33. SIGNATURE OF JURY <i>John Doe</i>	
34. SIGNATURE OF JURY <i>John Doe</i>		35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>		39. SIGNATURE OF JURY <i>John Doe</i>	
40. SIGNATURE OF JURY <i>John Doe</i>		41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>		45. SIGNATURE OF JURY <i>John Doe</i>	
46. SIGNATURE OF JURY <i>John Doe</i>		47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>		51. SIGNATURE OF JURY <i>John Doe</i>	
52. SIGNATURE OF JURY <i>John Doe</i>		53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>		57. SIGNATURE OF JURY <i>John Doe</i>	
58. SIGNATURE OF JURY <i>John Doe</i>		59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>		63. SIGNATURE OF JURY <i>John Doe</i>	
64. SIGNATURE OF JURY <i>John Doe</i>		65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
67. SIGNATURE OF JURY <i>John Doe</i>		68. SIGNATURE OF JURY <i>John Doe</i>		69. SIGNATURE OF JURY <i>John Doe</i>	
70. SIGNATURE OF JURY <i>John Doe</i>		71. SIGNATURE OF JURY <i>John Doe</i>		72. SIGNATURE OF JURY <i>John Doe</i>	
73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>		75. SIGNATURE OF JURY <i>John Doe</i>	
76. SIGNATURE OF JURY <i>John Doe</i>		77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>		81. SIGNATURE OF JURY <i>John Doe</i>	
82. SIGNATURE OF JURY <i>John Doe</i>		83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
85. SIGNATURE OF JURY <i>John Doe</i>		86. SIGNATURE OF JURY <i>John Doe</i>		87. SIGNATURE OF JURY <i>John Doe</i>	
88. SIGNATURE OF JURY <i>John Doe</i>		89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>		93. SIGNATURE OF JURY <i>John Doe</i>	
94. SIGNATURE OF JURY <i>John Doe</i>		95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>		99. SIGNATURE OF JURY <i>John Doe</i>	
100. SIGNATURE OF JURY <i>John Doe</i>		101. SIGNATURE OF JURY <i>John Doe</i>		102. SIGNATURE OF JURY <i>John Doe</i>	

BUREAU V. S.

JAN 15 1933

RECEIVED

314

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN TB <b>58 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>Baltimore</b>		3. NAME OF DECEASED (If not in hospital, give street address) <b>Veterans Administration Hospital</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>2008 Madison Avenue</b>	
4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>1958</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>December 16, 1894</b>
9. AGE (In years last birthday) yrs. <b>63</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doorman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Theater</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Andrew A. Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Purnell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>217-18-6586</b>	
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA LEFT LUNG WITH METASTASIS</b> <b>162.1 XXXXX TO LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>November 5, 1957</b> , to <b>January 1, 1958</b> , and that death occurred at <b>9:10 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Md.</b> DATE SIGNED <b>1/2/58</b>			
ACTUAL SIGNATURE <b>Donald D. Mark</b> M.D.		PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 6, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ELROY O. WILSON</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 9 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. No. 100

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Birth		Place of Death	
JAMES H. HARRIS		45		M		W		1880		1925		BALTIMORE, MD		BALTIMORE, MD	
Cause of Death		Disease		Complication		Injury		Poison		Other		Occupation		Education	
Heart Disease		Coronary Artery Disease		Hypertension		Stroke		Diabetes		Obesity		Teacher		High School	
Time of Death		Place of Death		Attending Physician		Medical Examiner		Funeral Home		Burial Place		Burial Date		Burial Time	
10:00 AM		Home		Dr. J. H. Smith		Dr. J. H. Smith		J. H. Smith & Co.		Greenwood Cemetery		1925		10:00 AM	
Signature of Physician		Signature of Medical Examiner		Signature of Funeral Home		Signature of Burial Place		Signature of Burial Date		Signature of Burial Time		Signature of Burial Place		Signature of Burial Date	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

BUREAU V. 5

JAN 9 1928

RECEIVED

CERTIFICATE OF DEATH

00303

Reg. Dist. No.

315

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>7 hrs. 50mins.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. STREET ADDRESS <b>844 Cherry Hill Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>I.</b> Last <b>JACKSON</b>				4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/14/14</b>	
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bootblack</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Department Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Lula Lee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>				16. SOCIAL SECURITY NO. <b>212-01-0482</b>			
17. INFORMANT <b>Clin. Rec. Div, Vets. Admin. Hospital, Ft. Howard, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE, RIGHT</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>19 HOURS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>January 7 1PM</b> 19 <b>58</b> , to <b>January 7 8:50PM</b> 19 <b>58</b> , and that death occurred at <b>8:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b> DATE SIGNED <b>1/8/58</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>Chien Wei Lan, M.D.</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-13-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles G. Cooper</b> ADDRESS <b>Charles G. Cooper, 512 N. Carrollton Ave, Balto, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

1AN 27 1953

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transfer permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00304

## 316 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kingsville</u>		LENGTH OF STAY (in this place) <u>34 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kingsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Jerusalem Rd.</u>				STREET ADDRESS (if rural give location) <u>Jerusalem Rd.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Charles E. Jones</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Jan. 25 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 8, 1893</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edgewood Arsenal</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Kinderfodder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 1</u>		17. INFORMANT & ADDRESS <u>Mrs. Nellie A/Jones Kingsville, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
163X IMMEDIATE CAUSE (A) <u>Carcinoma of Lung with metastasis</u>						<u>1 1/2 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>April 1, 1955</u> , <b>to</b> <u>Jan. 25, 1958</u> , <b>that I last saw the deceased</b> <b>alive on</b> <u>Jan. 25, 1958</u> , <b>and that death occurred at</b> <u>4:45</u> P.M., <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>William G. Tyson</u> M.D. <b>ADDRESS</b> (Street, city, town, state) <u>Kingsville, Md.</u> <b>DATE SIGNED</b> <u>1-25-58</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 28, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Balto. U.S. National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>7401 Belair Rd.</u>	
DATE <u>JAN 28 '58</u>							

# CERTIFICATE OF DEATH

1. DEATH REPORTED FIRST BY DOCTOR

34 yrs

BUREAU Y. 1

JAN 28 1959

RECEIVED

INSTRUCTIONS

## 317 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>4 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
f. STREET ADDRESS <b>1215 East Biddle Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SOLOMON</b>		4. DATE OF DEATH <b>January 27 19 58</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 3, 1889</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		12. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
13. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Benjamin Jones</b>		16. MOTHER'S MAIDEN NAME <b>Mary Simms</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		18. SOCIAL SECURITY NO. <b>157-05-9225</b>	
19. ADDRESS <b>Clin/Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO <b>CEREBRAL ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>UNKNOWN</b>	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>		22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
25. TIME OF INJURY Hour a. p. m. <b>19</b>		26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town) (County) (State)	
29. I certify that I attended the deceased from <b>January 23, 19 58</b> , to <b>January 27, 19 58</b> , that I last saw the deceased alive on <b>January 27, 19 58</b> , and that death occurred at <b>10:25 AM</b> , from the causes and on the date stated above.		30. ADDRESS (Street, city or town, state) DATE SIGNED <b>1-27-58</b>	
31. ACTUAL SIGNATURE <b>Chien Wei Lan</b>		32. M.D. <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
33. PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN</b>		34. MD	
35. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		36. DATE THEREOF <b>1-29-58</b>	
37. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>		38. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
39. FUNERAL DIRECTOR'S SIGNATURE <b>ADDRESS</b>		40. REC'D BY REGISTRAR <b>JAN 29 1958</b>	
41. REGISTRAR'S SIGNATURE <b>W. J. Seach</b>		42. REGISTRAR'S SIGNATURE <b>W. J. Seach</b>	

CHARLES R LAW FUNERAL HOME 802-04 MADISON AVE BALTIMORE MD

VS A15 (4)  
15M 9/58

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of toxicologist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of social worker	
28. Signature of psychologist		29. Signature of psychiatrist		30. Signature of sociologist	
31. Signature of anthropologist		32. Signature of linguist		33. Signature of geographer	
34. Signature of historian		35. Signature of archaeologist		36. Signature of paleontologist	
37. Signature of zoologist		38. Signature of botanist		39. Signature of geologist	
40. Signature of astronomer		41. Signature of meteorologist		42. Signature of oceanographer	
43. Signature of climatologist		44. Signature of hydrologist		45. Signature of geophysicist	
46. Signature of geodesist		47. Signature of cartographer		48. Signature of surveyor	
49. Signature of engineer		50. Signature of architect		51. Signature of artist	
52. Signature of musician		53. Signature of actor		54. Signature of writer	
55. Signature of publisher		56. Signature of printer		57. Signature of bookseller	
58. Signature of librarian		59. Signature of archivist		60. Signature of paleographer	
61. Signature of numismatist		62. Signature of philologist		63. Signature of lexicographer	
64. Signature of etymologist		65. Signature of linguist		66. Signature of geographer	
67. Signature of historian		68. Signature of archaeologist		69. Signature of paleontologist	
70. Signature of zoologist		71. Signature of botanist		72. Signature of geologist	
73. Signature of astronomer		74. Signature of meteorologist		75. Signature of oceanographer	
76. Signature of climatologist		77. Signature of hydrologist		78. Signature of geophysicist	
79. Signature of geodesist		80. Signature of cartographer		81. Signature of surveyor	
82. Signature of engineer		83. Signature of architect		84. Signature of artist	
85. Signature of musician		86. Signature of actor		87. Signature of writer	
88. Signature of publisher		89. Signature of printer		90. Signature of bookseller	
91. Signature of librarian		92. Signature of archivist		93. Signature of paleographer	
94. Signature of numismatist		95. Signature of philologist		96. Signature of lexicographer	
97. Signature of etymologist		98. Signature of linguist		99. Signature of geographer	
100. Signature of historian		101. Signature of archaeologist		102. Signature of paleontologist	

RECEIVED  
JAN 29 1958  
BUREAU V. 8

318

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>?</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 Wade Ave</u>		d. STREET ADDRESS <u>16 Wade Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>MILADIN</u> Middle <u>KARAPANZA</u> Last <u>KARAPANZA</u>		4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/6/85</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal mine</u>	
11. BIRTHPLACE (State or foreign country) <u>Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nikola Karapanzo</u>		14. MOTHER'S MAIDEN NAME <u>Stana Papich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Stana Papich</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>523.3</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor pulmonale.</u> (c) <u>Pneumohemorrhosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 57</u> , 19 <u>57</u> , to <u>11/11/58</u> , that I last saw the deceased alive on <u>1/10/58</u> , 19 <u>58</u> , and that death occurred at <u>4:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Mc Grath M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28md</u> DATE SIGNED <u>1/13/58</u>	
PHYSICIAN'S NAME (Type) <u>W. E. Mc Grath M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stouck Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE <u>1 4 58</u>
			24b. REGISTRAR'S SIGNATURE <u>W. E. Mc Grath</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V. S.**

JAN 14 1958

RECEIVED



Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>108 Cherrydell Rd.</b>		d. STREET ADDRESS <b>108 Cherrydell Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Joseph Kavanagh Sr.</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>29</b> Year <b>19 58</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1894</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Zookeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Park Board</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>John J. Kavanagh</b>		14. MOTHER'S MAIDEN NAME <b>Bridget Murray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Mrs. J.J. Kavanagh 108 Cherrydell Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis C.V.D.</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Balto.</b>		20g. (County) <b>Balto.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Jan 25, 1958</b> to <b>Jan 29, 1958</b> , that I last saw the deceased alive on <b>Jan 25, 1958</b> , and that death occurred at <b>8 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3325 Frederick Ave</b> DATE SIGNED <b>J. C. Pound</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-1-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>	
22d. LOCATION (City, town, or county) <b>Balto.</b>		22e. (State) <b>Md.</b>		22f. REGISTRAR'S SIGNATURE <b>W. L. Search</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home, Catonsville, Md.</b>		23a. ADDRESS <b>Farley Funeral Home, Catonsville, Md.</b>		23b. REGISTRAR'S SIGNATURE <b>W. L. Search</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00308

320

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7602 Harford Rd.</u>				d. STREET ADDRESS <u>7602 Harford Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>Albert</u> Last <u>Keil</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>8,</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 11, 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>71</u> Days <u>19</u> Hours <u>58</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millwright</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Electric</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frederick Keil</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Berger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-3125</u>		17. INFORMANT <u>Mr. Robert Keil</u> Address <u>7602 Harford Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thromboses</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 mo.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Oct 8, 1957</u> to <u>Jan 8, 1958</u> , that I last saw the deceased alive on <u>Jan 4, 1958</u> , and that death occurred at <u>10:58</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3805 Belair Rd. Baltimore, Md.</u> DATE SIGNED <u>Jan 9/58</u>							
ACTUAL SIGNATURE <u>J S Standing</u>				M.D. <u>3805 Belair Rd. Baltimore, Md.</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 11, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lanshan Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

AN 14 1958

BUREAU V. 81

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK 22</b>		c. LENGTH OF STAY IN 1b <b>4 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1900 TYLER ROAD</b>		d. STREET ADDRESS <b>1900 TYLER RD</b>	
3. NAME OF DECEASED (Type or print) <b>ETHEL DRUCILLA STUART KELLER</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>FEM.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 19, 1906</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK - TYPEST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV.</b>	
11. BIRTHPLACE (State or foreign country) <b>TENN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BARTLY STUART</b>		14. MOTHER'S MAIDEN NAME <b>MARY CLARK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>408-10-3955</b>	
17. INFORMANT <b>JAMES T. KELLER</b>		Address <b>SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>161X</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6-51</b> , 19 <b>57</b> , to <b>1-5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>12-26</b> , 19 <b>57</b> , and that death occurred at <b>30</b> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jack C. Collins</b>		ADDRESS (Street, city or town, state) <b>2 KIRKSHIP BALTO 22</b>	
PHYSICIAN'S NAME (Type) <b>JACK C. COLLINS</b>		DATE SIGNED <b>1-6-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/8/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. CO., MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Duke Bradley, Dundalk, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 7 '58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Reberich</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V. S.**

JAN 7 1968

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration information prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00310

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - WOODLAWN</b>		c. LENGTH OF STAY IN 1b <b>3 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1705 MEADOW COURT, BALTO.</b>		e. STREET ADDRESS <b>1925 LELAND AVE.</b>	
3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>G.</b> Last <b>KING</b>		4. DATE OF DEATH Month <b>1</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 23, 1889</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>7</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WHOLESALE CRACKER BUSINESS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WHOLESALE CRACKER BUSINESS</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE KING</b>		14. MOTHER'S MAIDEN NAME <b>LENA STUMPF</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>21309-684</b>	
17. INFORMANT <b>GEORGIA GOSLINE</b>		Address <b>1705 MEADOW COURT BALTO. 7, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>DEGENERATIVE HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 YEARS</b> <b>10 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC. 1, 1957</b> to <b>JANUARY 7, 1958</b> , that I last saw the deceased alive on <b>JANUARY 2, 1958</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edwin L. Pierpont</b>		ADDRESS (Street, city or town, state) <b>8204 LIBERTY RD., BALTO. 7, MD.</b>	
PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, MD</b>		DATE SIGNED <b>1/7/58</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 10/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Belair Mem Park</b>		22d. LOCATION (City, town, or county) (State) <b>Belair Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Norwig Sons</b>		ADDRESS <b>2024 Orleans St</b>	
24a. REC'D BY REGISTRAR <b>JAN 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Quelan</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. KIRK		MALE		68		JAN 15 1898		BALTIMORE, MD.	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
RETIRED		HEART DISEASE		NATURAL		3 WEEKS		HOME	
DATE OF DEATH		HOUR OF DEATH		TEMPERATURE		PULSE		RESPIRATIONS	
JAN 25 1958		10:30 AM		100.0		90		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 25 1958		JAN 25 1958		JAN 25 1958		JAN 25 1958		JAN 25 1958	

BUREAU V. 3

JAN 9 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

322

## CERTIFICATE OF DEATH

00311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>62 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>9825 Harford Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>E.</b> Last <b>KIRBY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 21, 1908</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home Repairs</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Florence Blakeley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>				16. SOCIAL SECURITY NO. <b>312-09-7084</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b> DUE TO <b>CARCINOMA OF RIGHT LUNG</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b> <b>3 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>November 13, 1957</b> , to <b>January 14, 1958</b> , that death was caused by <b>GENERALIZED CARCINOMATOSIS</b> , and that death occurred at <b>12:40 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA HOSPITAL, FORT HOWARD, MARYLAND 1/14/58</b>							
ACTUAL SIGNATURE <b>Irving Freeman</b>				M.D. <b>VA HOSPITAL, FORT HOWARD, MARYLAND 1/14/58</b>			
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-18-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard Ruck Funeral Home, 5305 Harford Rd. Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 18 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

## RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

323

## CERTIFICATE OF DEATH

00312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN lb <b>1yr 3 mths</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Emma Mose Kitt</b>			4. DATE OF DEATH Month Day Year <b>January 22 1958</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec., 1874</b>		9. AGE (In years lost birthday) yrs. <b>83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>
13. FATHER'S NAME <b>Moe Moss</b>			14. MOTHER'S MAIDEN NAME <b>Dora Kebart</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 18, 1957</b> to <b>Jan. 22, 1958</b> , that I last saw the deceased alive on <b>Jan. 22, 1958</b> , and that death occurred at <b>2:00a</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Stella Wachsler</b>			ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 1-22-58</b>		
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>			Catonsville 28, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral</b>		22b. DATE THEREOF <b>1-23-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Balto</b>		22d. LOCATION (City, town, or county) (State) <b>md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jacobs Lewis Mc</b>			ADDRESS <b>3100 Cutaw Pl</b>		
24a. REC'D BY REGISTRAR <b>JAN 23 '58</b>			24b. REGISTRAR'S SIGNATURE <b>Quesada</b>		

RECEIVED



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00313

324

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowley's Quarters</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowley's Quarters</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 179 Long Beach Rd. Rt. #15</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Koks</b>		4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-5-1877</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>
13. FATHER'S NAME <b>Unkown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>168-05-6688</b>	17. INFORMANT <b>Frank Koks</b> Address <b>Same</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X</b> DUE TO <b>Cancer of the stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 9, 1958</b> , to <b>June 29, 1958</b> , that I last saw the deceased alive on <b>1/17, 1958</b> , and that death occurred at <b>9:00</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. L. Kolodziej</b>		ADDRESS (Street, city or town, state) <b>1325 Eastern Blvd Baltimore 21, Md</b>	
PHYSICIAN'S NAME (Type) <b>A. L. Kolodziej MD</b>		DATE SIGNED <b>1/27/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/1/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Bruzdinski</b>		ADDRESS <b>1407 Eastern Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 3 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

325

## CERTIFICATE OF DEATH

00314

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>58 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>				d. STREET ADDRESS <b>Mill Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>P</b> Last <b>KOTCHEN</b>				4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/10/10</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>19</b> Hours <b>58</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metal Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Michael Kotchen</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Dorsch</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>213-12-3829</b>		17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA LEFT HYPO PHARYNX</b> <b>147X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>EMACIATION</b>				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 6</b> , 19 <b>57</b> , to <b>January 3</b> , 19 <b>58</b> , and that death occurred at <b>1:20 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald D. Mark</b>				ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Md.</b>		DATE SIGNED <b>1/4/58</b>	
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-7-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook - Blight, Inc</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alberich</b>	

WILLIAM COOK-BLIGHT INC. FUNERAL HOME, 6009 Harford Rd., Balto., Md.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
**CERTIFICATE OF DEATH**

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		75		1888	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1111 N. E. St.		Retired		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE OF DEATH		MANNER OF DEATH	
Jan 8, 1958		Home		1111 N. E. St.		Natural	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE OF DEATH		MANNER OF DEATH	
Jan 8, 1958		Home		1111 N. E. St.		Natural	

**RECEIVED**  
 JAN 8 1958  
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

326

## CERTIFICATE OF DEATH

00315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>42 FREDERICK ROAD</u>		d. STREET ADDRESS <u>42 FREDERICK ROAD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHANNA MARY KRAMER</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 19, 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 5, 1875</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Adolphus H. KRAMER</u>		Address <u>42 FREDERICK Rd Ellicott City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE SIGNIFICANT</u>			INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 19</u> , 19 <u>58</u> , to <u>JAN 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN 9</u> , 19 <u>58</u> , and that death occurred at <u>9:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Ellicott City, Md.</u> <u>Jan 20, 1958</u> It also attended by Dr. Warren at Laurel.			
ACTUAL SIGNATURE <u>Donald E. Fisher</u>		M.D. <u>Ellicott City, Md.</u>	
PHYSICIAN'S NAME (Type) <u>DONALD E. FISHER M.D.</u>		<u>ELLICOTT CITY MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 22, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, Catonsville 28, Md.</u>		ADDRESS <u>420.1</u>	
24a. REC'D BY REGISTRAR <u>JAN 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	



# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1938

1938

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF FUNERAL HOME</p>		<p>16. SIGNATURE OF BURIAL PLACE</p>	
<p>17. SIGNATURE OF CEMETERY</p>		<p>18. SIGNATURE OF INTERMENT</p>	
<p>19. SIGNATURE OF BURIAL PLACE</p>		<p>20. SIGNATURE OF INTERMENT</p>	
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<p>99. SIGNATURE OF BURIAL PLACE</p>		<p>100. SIGNATURE OF INTERMENT</p>	

BUREAU V. S.

JAN 24 1938

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
327 CERTIFICATE OF DEATH									
Reg. Dist. No. 00316									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>461 WHITFIELD RD.</u>					d. STREET ADDRESS <u>461 WHITFIELD RD.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADELINE</u> Middle <u>LAMBERT</u> Last					4. DATE OF DEATH Month <u>JAN.</u> Day <u>20</u> Year <u>1958</u>				
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 5, 1879</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.H.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>PHILIP HAXEL</u>					14. MOTHER'S MAIDEN NAME <u>ATPOLONIA SCHWING</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. MILDRED REISINGER</u> <u>461 WHITFIELD RD.</u>				
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis Postoperative carcinoma of breast</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>1/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/20</u> , 19 <u>58</u> , and that death occurred at <u>5:45</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1 Mallon Hill Ave Baltimore 29, Md.</u> DATE SIGNED									
ACTUAL SIGNATURE <u>Jama Thoben</u>			M.D. <u>1 Mallon Hill Ave Baltimore 29, Md.</u>						
PHYSICIAN'S NAME (Type) <u>NOLAN, J. J.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>			22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUNERAL DIR. 4141 EDMONDSON AVE</u>					24a. REC'D BY REGISTRAR DATE <u>JAN 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>		

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 23 1958</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
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100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

JAN 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

328

Item 12 Film 224 1-17-58 at

CERTIFICATE OF DEATH

00317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights</u> 1636.2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>6229 Shady Side Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Lawrence</u> Last <u>Lawrence</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Sidney James</u>			14. MOTHER'S MAIDEN NAME <u>Adeline</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Sarah A. Lawrence (wife)</u> Address <u>Capital Heights 6229 Shady Side Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary thrombosis and infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Degenerative myocardial fibrosis</u> (c) <u>Arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>  </u> years <u>  </u> years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inanition; dehydration; senile brain disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> o. p. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>Sept 12</u> , 19 <u>57</u> , to <u>Jan 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 11</u> , 19 <u>58</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gertrude J. Fleischmann</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove ST. H. 10413</u>		DATE SIGNED <u>1. 12. 58</u>	
PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMANN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) <u>Swindell, Md.</u>		(State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee Son - Wash. D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

BUREAU A. S.

AN 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00318

Reg. Dist. No.

329

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u> c. LENGTH OF STAY IN 1b			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BELLONA LANE</u>			d. STREET ADDRESS <u>BELLONA LANE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>HENRY FRANCES LeBrun</u> First Middle Last			4. DATE OF DEATH <u>January 29 1958</u> Month Day Year		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 19, 1908</u> yrs. <u>49</u>		9. AGE (In years last birthday) <u>49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE INS.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE INS.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>HARRY A. LEBRUN</u>			
14. MOTHER'S MAIDEN NAME <u>EMMA FRANCES</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>BEATRICE W. LEBRUN - BELLONA LANE</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (c), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN CAUSES AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SHERWOOD EPISCOPAL</u>	
22d. LOCATION (City, town, or county) (State) <u>COCKEYSVILLE - MD.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Townson, Inc</u> ADDRESS <u>1050 N. YORK RD</u>			
24a. REC'D BY REGISTRAR <u>Feb 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>			



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU K. B.

APR 4 1958

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH

00319

330

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTRY <u>SPRINGFIELD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>SPRINGFIELD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPRINGFIELD</u>	
TOWN <u>SPRINGFIELD</u>		TOWN <u>SPRINGFIELD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>711 L Street</u>		STREET ADDRESS (If rural, give location) <u>1425 B. L. Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>William</u> (Middle) <u>Le Grant</u> (Last) <u>Le Grant</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>15</u> (Year) <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 4, 1888</u>
9. AGE last birthday <u>69</u> yrs. <u>15</u> months <u>15</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Luther Le Grant</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>1425 B. L. Ave</u>	
17. INFORMANT AND ADDRESS <u>Angela Robinson 711 L Street</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

151X Immediate cause

(a)

Broncho-Pneumonia2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Carcinoma of Stomach1 month

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-14, 1957, to 1-15, 1958, that I last saw the deceasedalive on 1-15, 1958, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REG'D BY JAN 17 1958

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JAN 17 1959

RECEIVED

331  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>Leymer Road</b>			
3. NAME OF DECEASED (Type or print) First <b>PHILIP</b> Middle <b>J.</b> Last <b>LEHR</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1/5/73</b>	
9. AGE (In years last birthday) <b>84 yrs.</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min.		11. IF UNDER 24 HRS. Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min.		12. IF UNDER 24 HRS. Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tailor Shop</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Father's name is unknown</b>				14. MOTHER'S MAIDEN NAME <b>Mother's name is unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>SAW</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>EMPHYSEMA</b>							
19. INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from <b>December 31, 1957, to January 4, 1958</b> , and that death occurred at <b>6:47A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald D. Mark</b>				ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b>			
DATE SIGNED <b>1/5/58</b>				DATE SIGNED <b>1/5/58</b>			
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-8-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b>				24a. REC'D BY REGISTRAR <b>Wm Cook-Blight, Inc.</b>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JAN 8 1938

RECEIVED

332

## CERTIFICATE OF DEATH

00321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 1615.2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>-</u> Last <u>Leiner</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/56</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jack Leiner</u>		14. MOTHER'S MAIDEN NAME <u>May Leiner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Owings Mills, Md. School</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>beginning broncho-pneumonia</u> 754.2 DUE TO Intraventricular septal defect of the heart (b) <u>Mongolism</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>approx. 12 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rich. E. Linderberg (Phys.)</u>		ADDRESS (Street, city or town, state) <u>Rosewood School</u>	
PHYSICIAN'S NAME (Type) <u>Rich. E. Linderberg (Physician)</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1/28-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Univ</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Levinson + Bus</u>		ADDRESS <u>1128 26 W. Hyattsville</u>	
24a. REC'D BY REGISTRAR <u>Jan 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Outreach</u>	

MEDICAL CERTIFICATION

2

1

12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

W. M. BOKID

BUREAU V. E.

JAN 29 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

333

## CERTIFICATE OF DEATH

Reg. Dist. No.

00322

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3V01.4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>		d. STREET ADDRESS <u>3548 9<sup>th</sup> ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Luka</u> Middle <u>B.</u> Last <u>Leonard</u>		4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-65</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>VRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Jordan</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Age -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1, 1952</u> , to <u>Jan 7, 1958</u> , that I last saw the deceased alive on <u>Jan 7, 1958</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff Jr</u> M.D. <u>4605 EDMONDSON AVE</u>		DATE SIGNED <u>1/7/58</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u>		ADDRESS <u>130 E. Fort Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

CERTIFICATE OF DEATH

See Dist No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK		15. SIGNATURE OF WITNESSES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00323

334

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN TB <b>1 Yr. 9 Mos. 6 Das.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		01022	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Sheppard &amp; Enoch Pratt Hospital</b>		d. STREET ADDRESS <b>UNK NOW 4</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Francina</b> Middle <b>Freese</b> Last <b>Lichtenstein</b>		4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 18, 1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Peter C. Freese</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. King</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Term</b> <b>2 yr +</b> <b>2 yr +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Brain Disease: Amputation left leg</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 16, 1956</b> , to <b>Jan 22, 1958</b> , that I last saw the deceased alive on <b>Jan 21, 1958</b> , and that death occurred at <b>4:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sheppard Pratt Hosp. Towson - 4, Md.</b> DATE SIGNED <b>Jan 23, 1958</b>			
ACTUAL SIGNATURE <b>W. W. Elgin</b>		M.D. <b>Sheppard Pratt Hosp. Towson - 4, Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. W. Elgin</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-25-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Auburn. N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook</b>		24a. REC'D BY REGISTRAR <b>Jan 24 '58</b>	
ADDRESS <b>1217 St. Paul St.</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>	

BUREAU V. B.

JAN 24 1958

RECEIVED

335

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A. A.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> 02X-2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>				d. STREET ADDRESS <b>Brookfield Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>KATE</b> Middle <b>R.</b> Last <b>LIPSCOMB</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>10.</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel T. Wright</b>				14. MOTHER'S MAIDEN NAME <b>Mary Christie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Charles L. McNutt - Brookfield Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE</b> <b>443X</b> DUE TO (b) <b>PULMONARY EDEMA &amp; KIDNEY FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>HYPERTENSIVE C.V. DISEASE -</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>10 YEARS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>JUNE 1</b> , 19 <b>57</b> , to <b>JAN 10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>JAN 10</b> , 19 <b>58</b> , and that death occurred at <b>7:18 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas E. Wheeler</b> M.D.				ADDRESS (Street, city or town, state) <b>Randall Rd. Md.</b>			
DATE SIGNED <b>1/11/58</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/13/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekner &amp; Sons, Balto., Md.</b>				24a. REC'D BY REGISTRAR <b>Jan 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. J. Tiekner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JAN 14 1958

RECEIVED



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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>55</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>				d. STREET ADDRESS <b>210 W. Penna. Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>ADELE CLUNET LITSINGER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>17</b> , Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 27, 1875</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Victor Clunet</b>				14. MOTHER'S MAIDEN NAME <b>Mary Shannon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Family records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>June 10, 1953</b> , to <b>Jan 17, 1958</b> , that I last saw the deceased alive on <b>Jan 17, 1958</b> , and that death occurred at <b>4 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6805 York Rd Baltimore 12 Md</b> DATE SIGNED <b>1/17/58</b>							
ACTUAL SIGNATURE <b>Laurence C. Post</b>		M.D. <b>6805 York Rd Baltimore 12 Md 1/17/58</b>					
PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 20, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sam Burns Lono</b>			ADDRESS <b>Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 20 1958</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 20 1953

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>918 Weatherbee Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>E.</b> Last <b>LONG</b>		4. DATE OF DEATH Month <b>January</b> Day <b>30</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1902</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice Pres.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machinist Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Long</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Morris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Mrs. Florence M. Long - 918 Weatherbee Rd.</b>		Address <b>Towson 4, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/31/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>2/3/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Sienkiewicz &amp; Sons - Balto.</b>		24. REC'D BY REGISTRAR DATE <b>FEB 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Overman</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 4 1968

BUREAU V. 2

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [REDACTED]  
AGE: [REDACTED]  
SEX: [REDACTED]  
RACE: [REDACTED]  
DATE OF BIRTH: [REDACTED]  
PLACE OF BIRTH: [REDACTED]  
DATE OF DEATH: [REDACTED]  
PLACE OF DEATH: [REDACTED]  
CAUSE OF DEATH: [REDACTED]  
MANNER OF DEATH: [REDACTED]  
SIGNATURE OF EXAMINER: [REDACTED]  
OFFICE OF THE MEDICAL EXAMINER: [REDACTED]

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Catonsville Boarding Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3401.4</b> ✓	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>414 Bretton Place</b>	
3. NAME OF DECEASED (Type or print) <b>Jane (Jennie)</b> First <b>MacKinnon</b> Middle Last		4. DATE OF DEATH <b>Jan.</b> <b>12th</b> <b>1958</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 1" 1868</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>William Baxter</b>		14. MOTHER'S MAIDEN NAME <b>Abbagail</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Marion C. Baxter</b> Address <b>414 Bretton Place</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE EPIDURAL HEMORRHAGE</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO-SCLEROTIC CHANGES - VASCULAR DISEASE</b> DUE TO <b>DISEASE</b> (c) <b>PNEUMONITIS</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>493x</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/1/58</b> to <b>1/12/58</b> , that I last saw the deceased alive on <b>1/12/58</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5800 Edmonson Ave Baltimore, Md.</b> DATE SIGNED <b>1/13/58</b>			
ACTUAL SIGNATURE <b>John H. Shaw</b> M.D.			
PHYSICIAN'S NAME (Type) <b>JOHN H. SHAW MD BALD. 281 MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 14" 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Lamoreaux</b>		ADDRESS <b>510 Liberty Heights Avenue</b>	24a. REC'D BY REGISTRAR <b>DATE</b> 24b. REGISTRAR'S SIGNATURE <b>10/1/58</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 14 1959

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00328

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>8yr7mthldy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Baltimore, Maryland</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Agnes</u> Last <u>Maguire</u>		4. DATE OF DEATH Month <u>January</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ireland U.S.A.</u>	
13. FATHER'S NAME <u>Owen Mulligan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mulligan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1955</u> , to <u>Jan. 16, 1958</u> , that I last saw the deceased alive on <u>Jan. 16, 1958</u> , and that death occurred at <u>6:25 a.m.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Jonas R. Rappaport</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> <u>1-16-58</u>			
PHYSICIAN'S NAME (Type) <u>Jonas R. Rappaport, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST Joseph Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>TEXAS</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F. EVANS + SON</u>		ADDRESS <u>8802 HARFORD Rd.</u>	
24a. REC'D BY REGISTRAR <u>JAN 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quinn Smith</u>	

BUREAU V. S.

JAN 22 1958

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00329

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		c. LENGTH OF STAY IN 1b <u>8 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bacon Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RAFFAEL</u> (First <u>Ralph</u> Middle <u>Marks</u> Last <u>Marchesi</u> )		4. DATE OF DEATH Month <u>JAN</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-3-1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>general</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>????</u>		14. MOTHER'S MAIDEN NAME <u>????</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Elmer Mentzell, ? White Hall, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> (c) <u>420.1</u> DUE TO <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1/9/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		22d. LOCATION (City, town, or county) (State) <u>Texas, Cockeysville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 10 '58</u>	
ADDRESS <u>622 York Rd., Towson 4, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

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BUREAU V. S.

JAN 10 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 205 CERTIFICATE OF DEATH

Reg. Dist. No. 00330

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. LENGTH OF STAY IN 1b <b>3 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>6648 DUNBAR Rd</b>		e. STREET ADDRESS <b>1930 DENBURY DRIVE</b>	
3. NAME OF DECEASED (Type or print) <b>CATHERINE MARY YAEGER MARTIN</b>		4. DATE OF DEATH <b>1-7-58</b> 19 <b>58</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 21, 1915</b>
9. AGE (In years last birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK YAEGER</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE NESZLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-07-6724</b>	
17. INFORMANT <b>CHAS. J. MARTIN, SR., DUNDALK, MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>193.0</b> DUE TO <b>glioma of brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 24, 1957</b> to <b>Oct 7, 1958</b> , that I last saw the deceased alive on <b>Oct 6, 1958</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David H. Andrew</b>		ADDRESS (Street, city or town, state) <b>33 Dundalk Ave Dundalk, Md</b> DATE SIGNED <b>1/7/58</b>	
PHYSICIAN'S NAME (Type) <b>David H. Andrew</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART JESUS</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brink Bralley, Dundalk, Md</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 10 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Andrew</b>	



BUREAU V. S.

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341

## CERTIFICATE OF DEATH

00331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home Towson Md.</u>				d. STREET ADDRESS <u>318 Cheaseapke Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Louisa</u> Middle <u>Martin</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Stegerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Arthur M. Martin</u> Address <u>4212 Annatana Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Generalized Arterio-Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>8 days</u> <u>20 1/2 to ?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Towson</u> , 19 <u>57</u> , to <u>Towson</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 7</u> , 19 <u>58</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Tos. F. Seelbach</u>				ADDRESS (Street, city or town, state) <u>200 W. Penna. Ave</u>			
DATE SIGNED <u>1/10/58</u>							
PHYSICIAN'S NAME (Type) <u>Tos. F. Seelbach</u>				TOWSON 4, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 11, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louisa Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE		RELIGION	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		PREVIOUS ILLNESS		TREATMENT	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF SURGEON	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		PREVIOUS ILLNESS		TREATMENT	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF SURGEON	

BUREAU V. S.

JAN 14 1938

RECEIVED

Handwritten signature and date: Jan 14 1938

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 34 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00332

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradshaw</b>		c. LENGTH OF STAY IN 1b <b>instant</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa Rural</b>		12x-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>Singer Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>MASON</b>				4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 22, 1902</b>	
9. AGE (in years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>12</b>		11. IF UNDER 24 HRS. Hours <b>12</b> Min. <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Com., Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>							
13. FATHER'S NAME <b>William H. Mason</b>				14. MOTHER'S MAIDEN NAME <b>Lindy J. Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-22-5713</b>		17. INFORMANT <b>Margaret Mason</b>		Address <b>Joppa, R.D. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pontine hemorrhage due to</b> <b>443x</b> <b>MX</b> TO <b>Hypertensive Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/7/58</b>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>		22d. LOCATION (City, town, or county) (State) <b>Lorely, Balto., Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McBrayer</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Mason</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JAN 9 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 FilmG224 1-14-58 et

Item 7 FilmG224 1-14-58 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

343

CERTIFICATE OF DEATH

Reg. Dist. No.

00333

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE CO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLANDVILLE, MD.</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>BROOKLANDVILLE, MD.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN THOMAS MC CAFFREY</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 7 1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 11, 1887</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER-RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>THOMAS MC CAFFREY</b>				14. MOTHER'S MAIDEN NAME <b>Lillie C. Fisher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NONE</b>				16. SOCIAL SECURITY NO. <b>Family Records</b>			
17. INFORMANT <b>Family Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure.</b> <b>096.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Edema.</b> DUE TO (c) <b>Virus Infection.</b> INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>2 hrs</b> <b>10 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12/27</b> , 19 <b>57</b> , to <b>1/7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1/7</b> , 19 <b>58</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>19W Seminary Ave, Baltimore, Md.</b> DATE SIGNED <b>1/8/58</b> ACTUAL SIGNATURE <b>Bennett A. Stoen</b> M.D. <b>19W Seminary Ave, Baltimore, Md.</b> PHYSICIAN'S NAME (Type) <b>Bennett A. Stoen</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SATER'S CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>LUTHERVILLE, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Son's</b>				ADDRESS <b>Towson 4, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 10 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>							

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

JAN 10 1955

RECEIVED



# 344 CERTIFICATE OF DEATH

Reg. Dist. No.....

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The **body** copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baldwin</u>	LENGTH OF STAY (in this place) <u>4 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baldwin</u>	STREET ADDRESS (If rural give location) <u>RD</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Ella Maude McCubbin</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 10 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March 7, 1879</u>
9. AGE last birthday <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baldwin, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John T. McCubbin</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Watkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>John W. McCubbin</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <u>Cerebral vascular Accident</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 2, 1958</u> , to <u>Jan. 10, 1958</u> , that I last saw the deceased alive on <u>Jan. 9, 1958</u> , and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above.			
SIGNATURE <u>William G. Tyson</u> M.D.		ADDRESS (Street, city, town, state) <u>Higginsville, Md.</u>	
DATE SIGNED <u>1-11-58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 13-58</u>	
NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>		LOCATION (City, town, or county) (State) <u>Sweet Air Balto Md</u>	
REC'D BY REGISTRAR <u>Jan 14 '58</u>		REGISTRAR'S SIGNATURE <u>William G. Tyson</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>William G. Tyson</u>		ADDRESS <u>Higginsville, Md.</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELATIONSHIP

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

DATE OF DEATH

BUREAU V. S.

JAN 14 1953

RECEIVED

## CERTIFICATE OF DEATH

345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>2 Hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>1107 S. Linwood Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>L.</b> Last <b>McDONOUGH</b>				4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 11, 1895</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>City</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John C. McDonough</b>				14. MOTHER'S MAIDEN NAME <b>Mary Fahey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>217-26-1290</b>		17. INFORMANT <b>Clin/Rec., Vet. Adm. Hospital, Ft. Howard, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>INFARCTION OF MYOCARDIAL DUE AS CORONARY THROMBOSIS</b> 2 Hours DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 9 12:25 PM '58</b> to <b>Jan. 9 2:55 PM '58</b> and that death occurred at <b>2:55 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur G. Edwards, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Fort Howard, Maryland.</b> DATE SIGNED <b>1/9/58</b>			
PHYSICIAN'S NAME (Type) <b>Arthur G. Edwards, JR. M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/13/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Blair Road &amp; Moravia Ave., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JAN 16 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. B. Beach</b>			

John A. Moran, Funeral Director, Greenmount Ave &amp; 42nd St., Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JAN 16 1923

RECEIVED

346

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN ARM</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLEN ARM</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>HARTFORD Rd - Glenview Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Deborah</b> Middle <b>C</b> Last <b>McLean</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>10</b> Year <b>1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 22 - 1867</b>	9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>LAWRENCE B McLEAN</b>		Address <b>- SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Hypertension c Arterio-sclerotic Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>20+ yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Plays</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 1, 1958</b> to <b>Jan 9, 1958</b> that I last saw the deceased alive on <b>Jan 9, 1958</b> and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank T. Kasik</b>				ADDRESS (Street, city or town, state) <b>9005 Hartford Rd BALTO 14 MD</b>			
DATE SIGNED <b>1/10/58</b>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>FRANK T KASIK JR.</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-13-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hiss Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>PARKVILLE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHAS F EVANS + SON</b>				ADDRESS <b>8802 HARTFORD RD</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 15 '58</b>	
24b. REGISTRAR'S SIGNATURE				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

347

CERTIFICATE OF DEATH

00337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Baltimore 12</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>214 Rodgers Forge Rd.</b>				/ d. STREET ADDRESS <b>214 Rodgers Forge Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Calvin Meck</b>				4. DATE OF DEATH Month Day Year <b>Jan. 18 19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Oct. 5, 1899</b>		9. AGE (In years last birthday) yrs. <b>58</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Copy reader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sun Papers</b>		11. BIRTHPLACE (State or foreign country) <b>Reading, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Calvin Meck</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ruth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-2330</b>		17. INFORMANT <b>Mrs. Robert C. Meck, 214 Rodgers Forge Rd.</b> Address <b>Baltimore 12, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiovascular disease</b> 3 yrs. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 1955</b> , to <b>January 18, 1958</b> , that I last saw the deceased alive on <b>January 18, 1958</b> , and that death occurred at <b>7:40 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert E. Ensor</b>				ADDRESS (Street, city or town, state) <b>29 Alleghany Ave., Towson, Md.</b> DATE SIGNED <b>1/18/58</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT E. ENSOR, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Burns Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Z. Gans</b> ADDRESS <b>Waynesboro, Pa.</b>				24a. REC'D BY REGISTRAR <b>JAN 20 '58</b> DATE		24b. REGISTRAR'S SIGNATURE <b>W. Z. Gans</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 20 1938	
AGE		SEX	
65		M	
RACE		RELIGION	
W		M	
BIRTH DATE		BIRTH PLACE	
JAN 15 1873		BALTIMORE, MD	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 15 1900		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
Physician		Burial Place	
J. H. Harris		Catholics	
Burial Date		Burial Place	
JAN 22 1938		Catholics	
Signature of Physician		Signature of Registrar	
J. H. Harris		J. H. Harris	
Date		Date	
JAN 20 1938		JAN 20 1938	

BUREAU V. S.

JAN 20 1938

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>348</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 02X+220 Glen Burnie, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>28 Main Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Gladys</b> Middle <b>Margaret</b> Last <b>Middlebrook</b>				4. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>1958</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1912</b>		9. AGE (In years last birthday) <b>45</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b>11</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Herbert Wolfe</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Donaldson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>590X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Acute glomerular Nephritis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>George M. Kieffer</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/14/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, AA, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James S. Kirkley</b>				24a. REC'D BY REGISTRAR <b>DATE JAN 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Reed</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JAN 14 1938  
BUREAU V. S.

## CERTIFICATE OF DEATH

00339

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3 Yr 1-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wayne Conv. Home</u>		d. STREET ADDRESS <u>3036 Dillon St.</u>	
3. NAME OF DECEASED (Type or print) <u>Andrew-Andy-Henry-Mierzewski-Meswiski-</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Standard Oil Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-4603</u>	
17. INFORMANT <u>Mrs. Josephine Mierzewski</u>		Address <u>3036 Dillon St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the</u> DUE TO <u>Prostate with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastases</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1956</u>	20f. (City or town) <u>1/21/58</u> (County) <u>  </u> (State) <u>  </u>
21. I certify that I attended the deceased from <u>1/20/58</u> , 19 <u>58</u> , to <u>1/21/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/20/58</u> , 19 <u>58</u> , and that death occurred at <u>5:10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John M. Grath</u> M.D.		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd</u>	
PHYSICIAN'S NAME (Type) <u>W. E. McGreth</u>		DATE SIGNED <u>1/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 25, 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>	22d. LOCATION (City, town, or county) (State) <u>German Hill Road Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Duda</u>		ADDRESS <u>2829 Hudson St. 24, Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

JAN 27 1958

RECEIVED  
JAN 27 1958



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

350

## CERTIFICATE OF DEATH

00340

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks Rural</u>		c. LENGTH OF STAY IN 1b <u>50 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				d. STREET ADDRESS <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LILLIE</u> First <u>M</u> Middle <u>MILLER</u> Last				4. DATE OF DEATH <u>June</u> Month <u>6</u> Day <u>1958</u> Year			
5. SEX <u>♀</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 26 - 1875</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Widow</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo B - Dubbs</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Rosier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Allen Miller - Sparks - Balto Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Cardio Sclerosis</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1</u> , 19 <u>50</u> , to <u>January 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 4</u> , 19 <u>58</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>1-6-58</u>							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D</u> <u>Hampstead Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 9 - 1958</u>		<u>St. Bernard</u>		<u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin A. Tipton</u> ADDRESS <u>Hampstead Md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 9 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Ant. Smith</u>	

BUREAU A. S.

1958 3 JAN

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00341

351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Keisterstown</i>		c. LENGTH OF STAY IN 1b <i>1 Hour</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>✓</i>		d. STREET ADDRESS <i>Manchester 06X-2</i>	
3. NAME OF DECEASED (Type or print) <i>SHIPLEY - L - MILLER</i>		4. DATE OF DEATH <i>Jan 17 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 28 - 1957</i>
9. AGE (In years last birthday) <i>9</i>		IF UNDER 1 YEAR Months <i>9</i> Days <i>19</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Eugene Miller</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Sellers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Eugene Miller - Manchester, Md</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>578X Andorin</i> DUE TO (b) <i>Viral Infection of gastro</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Intestinal Tract</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Mar 57</i> , 19 <i>57</i> , to <i>Jan 17</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Jan 17</i> , 19 <i>58</i> , and that death occurred at <i>10 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. H. Foard</i>		ADDRESS (Street, city or town, state) <i>23 N Main St</i>	
PHYSICIAN'S NAME (Type) <i>W. H. Foard M.D.</i>		DATE SIGNED <i>1/18/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan 18/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Lutheran Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Manchester, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwin C. Tipton, Hampstead Md</i>		24a. REC'D BY REGISTRAR <i>Jan 18 1958</i> 24b. REGISTRAR'S SIGNATURE <i></i>	

BUREAU V. S.

JAN 20 1958

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

00342

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Rosewood State F. School</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prickens</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo Mills Md.</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo -- Route # 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>Conowingo -- Route # 1</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>Leroy</u> Last <u>Miller</u>				<b>4. DATE OF DEATH</b> 1- 24 19 58			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>8/25/43</u>		9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>Elmer Leroy Miller</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Frances Burnett</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Rosewood Record</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO <u>464x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Phlebotrombosis in small pelvis</u> DUE TO (c) <u>Spastic Angeroplegia</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Due to former Sinus Thrombosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>Jan 26</u> , 19 <u>50</u> , to <u>Jan 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 24</u> , 19 <u>58</u> , and that death occurred at <u>11</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Rich. E. Early (Patrol)</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Rich. Gindenberg (Pathologist)</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Park</u>			
22d. LOCATION (City, town, or county) (State) <u>Bluewell, West Virginia</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Elms-Barns Rustatons Md</u>					
24a. REC'D BY REGISTRAR DATE <u>JAN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: \_\_\_\_\_

4. DATE OF BIRTH: \_\_\_\_\_

5. PLACE OF BIRTH: \_\_\_\_\_

6. OCCUPATION: \_\_\_\_\_

7. CAUSE OF DEATH: \_\_\_\_\_

8. DATE OF DEATH: \_\_\_\_\_

9. TIME OF DEATH: \_\_\_\_\_

10. PLACE OF DEATH: \_\_\_\_\_

11. SIGNATURE OF PHYSICIAN: \_\_\_\_\_

12. SIGNATURE OF REGISTRAR: \_\_\_\_\_

BUREAU V. S.

JAN 30 1958

RECEIVED

RECEIVED  
JAN 30 1958  
BUREAU V. S.



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>M.D.</u> b. COUNTY <u>Balti.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore rural</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6508 BANBURY RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES G. MILLS</u>				4. DATE OF DEATH <u>JAN. 11, 1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 24, 1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED LAUNDRYMAN, UP TO DATE LAUNDRY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>M.D.</u>			
11. BIRTHPLACE (State or foreign country) <u>USA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>MILLS</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>215-18-6366</u>			
17. INFORMANT <u>MR. CRESTON J. MILLS, 2503 HOLLINS ST.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While o. m. Not while o. m. <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/4</u> 19 <u>57</u> to <u>10/11</u> 19 <u>58</u> , that I last saw the deceased alive on <u>1/10</u> 19 <u>58</u> , and that death occurred at <u>10 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. M. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>6305 The Church Baltimore, Md.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL</u>		22d. LOCATION (City, town, or county) (State) <u>VIOLETVILLE M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUNERAL DIR. 4141 EDMONDSON</u>				ADDRESS <u>4141 EDMONDSON</u>		24a. REC'D BY REGISTRAR <u>JAN 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

JAN 14 1958

RECEIVED

354

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3101.4</b> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>1218 GREENMOUNT AVE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARLO MIRABILE</b>				4. DATE OF DEATH Month Day Year <b>1 - 6 - 1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-7-08</b>	
9. AGE (In years last birthday) <b>39</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE-REPAIRING</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>JOSEPH MIRABILE</b>				14. MOTHER'S MAIDEN NAME <b>MARY SOPHIA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>		17. INFORMANT Address <b>Hospital records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA.</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC INTERSTITIAL NEPHRITIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002x PULMONARY TUBERCULOSIS</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-6-</b> , 19 <b>57</b> , to <b>1-6-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-5-</b> , 19 <b>58</b> , and that death occurred at <b>1:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED ACTUAL SIGNATURE <b>William Newcomer</b> M.D. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-9-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00345

355

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Chapman Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>H.</b> Last <b>Mirassou</b>		4. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1914</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred Mirassou</b>		14. MOTHER'S MAIDEN NAME <b>Marie Lahouratate</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-3551</b>	
17. INFORMANT <b>Mrs. Catherine L. Mirassou</b>		Address <b>Kingsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Dis</b> DUE TO (c) <b>7 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>322.1 Chronic alcoholism</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-11, 1953</b> to <b>1/28, 1958</b> , that I last saw the deceased alive on <b>1/27, 1958</b> , and that death occurred at <b>3:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Fork, MD.</b> DATE SIGNED ACTUAL SIGNATURE <b>Clifford F. Hudson</b> M.D. PHYSICIAN'S NAME (Type) <b>CLIFFORD F. HUDSON</b> <b>FORK, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 31, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Stephen's</b>	22d. LOCATION (City, town, or county) (State) <b>Bradshaw, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Carroll Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 30 '58</b>	
ADDRESS <b>7401 Belair Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Att. Health</b>	







Reg. Dist. No. \_\_\_\_\_

**DEPUTY DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL CERTIFICATION

1. PLACE OF DEATH: o. COUNTY <u>Rosewood State Training School</u> <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>City</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. LENGTH OF STAY IN lb <u>3 years</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Baltimore, Maryland</u> <u>3y01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>						d. STREET ADDRESS <u>1106 Ramblewood Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Marlow</u> Last <u>Mitchell</u>						4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>19 58</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/28/08</u>		9. AGE (In years last birthday) yrs. <u>49</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William C. Mitchell (deceased)</u>						14. MOTHER'S MAIDEN NAME <u>(Wilhelmina) Minnie Schultz (deceased)</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Rosewood Records</u>		17. INFORMANT <u>Rosewood Records</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Retrotonsillar abscess and purulent bronchitis</u> <u>511X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Mongoloid Idiocy</u> DUE TO (c) <u>Scar formation in upper cervical cord due to</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>herniated disc.</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>1/17/58</u> ACTUAL SIGNATURE <u>Ric. Gubing (Pathologist)</u> M.D. PHYSICIAN'S NAME (Type) _____											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>			22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. L. Jones &amp; Sons</u>						ADDRESS <u>1700 Ave 17</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

RECEIVED

JAN 21 1938

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00347

357 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>				c. LENGTH OF STAY IN lb <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7911 35th. St.</u>				d. STREET ADDRESS <u>7911 35th. St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Pamela</u> Middle <u>Ann</u> Last <u>Morgan</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>8</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1957</u>		9. AGE (In years lost birthday) yrs. <u>11</u> Months <u>20</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W. Morgan</u>				14. MOTHER'S MAIDEN NAME <u>Moneta P. Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>James W. Morgan</u> Address <u>7911 35th. St. Balto., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/8</u> , 19 <u>58</u> , to <u>1/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/8</u> , 19 <u>58</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. M. Baumgardner</u> M.D.				ADDRESS (Street, city or town, state) <u>Balto md</u> DATE SIGNED <u>1/9/58</u>			
PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Josephine F. ...</u> ADDRESS <u>7401 Belair Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riverdale Apts. Apt. 16 C Fenway So</u>				d. STREET ADDRESS <u>Fenway So Riverdale Apts. Apt. 16C</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>L</u> Last <u>MORTIMER</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 5, 1893</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vet. Adm.</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Martin Mortimer</u>				14. MOTHER'S MAIDEN NAME <u>Annie Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Katherine M. Mortimer - Riverdale Apts.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Cardiac Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>Dec</u> Day <u>31</u> Year <u>1957</u> Hour a. m. <u>8:30 P</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec 31</u> , 19 <u>57</u> , to <u>Jan 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 10</u> , 19 <u>58</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irving R. Beck</u>				ADDRESS (Street, city or town, state) <u>901 FUSELAGE AVE. BALTIMORE 20 Md.</u>			
PHYSICIAN'S NAME (Type) <u>IRVING R. BECK, M.D.</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) <u>Balto.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner &amp; Sons - Balto 17th</u>				24a. REC'D BY REGISTRAR <u>DATE JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 359

Item 12 Film 9224 1-13-58 et

## CERTIFICATE OF DEATH

00349

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Notch Cliff near Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Road</u>				d. STREET ADDRESS <u>Glenarm Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Sister Mary Michaela Mueller</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25th, 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Keul</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Sister M. Peter Fourier</u> <span style="float: right;">Address <u>Notch Cliff, Md.</u></span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ga. Of large intestines</u> <u>1538</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>April</u> , 19 <u>52</u> , to <u>Dec. 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 31st</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7501 York Road Towson, 4, Md.</u> DATE SIGNED <u>Jan. 3. 58</u> ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-7-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM</u>		22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF, TOWSON MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Juler</u>				ADDRESS <u>9015 CONKLING ST. BALTO, 24, MD.</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>JAN 6 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>				24c. REGISTRAR'S SIGNATURE <u>  </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

JAN 7 1953

360

CERTIFICATE OF DEATH

00350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2yr 11 mths 7 dys</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata, Md.</b>				d. STREET ADDRESS <b>Route #2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Murphy</b> Last <b>Murphy</b>				4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1881</b>	9. AGE (In years last birthday) yrs. <b>76</b>	IF UNDER 1 YEAR Months <b>76</b>	IF UNDER 24 HRS. Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
13. FATHER'S NAME <b>Alphous Murphy</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Dec. 16</b> , 19 <b>57</b> , to <b>Jan. 23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan. 23</b> , 19 <b>58</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>			ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>1-23-58</b>				
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>			<b>Catonsville 28, Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-27-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cemetery</b>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Funeral Home</b>			ADDRESS <b>Waldorf Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 28 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Dee</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

361

## CERTIFICATE OF DEATH

00351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>32 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>--</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>H.</b> Last <b>MURPHY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 21, 1924</b>	
9. AGE (In years last birthday) yrs. <b>33</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman - Delivery</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bread Company</b>		11. BIRTHPLACE (State or foreign country) <b>Nanticoke, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Ezekiel Murphy</b>				14. MOTHER'S MAIDEN NAME <b>Vannie Dunn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Clinical Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE MYELOMA</b> <b>203X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <b>x</b> attended the deceased from <b>December 23, 19 57</b> , to <b>January 24, 19 58</b> and that death occurred at <b>2:45 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA HOSPITAL, FORT HOWARD, MARYLAND 1/24/58</b>							
ACTUAL SIGNATURE <b>Irving Freeman</b>				M.D. <b>VA HOSPITAL, FORT HOWARD, MARYLAND 1/24/58</b>			
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, Chief, Medical Service, VAH, Fort Howard, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-24-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wicomico County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b> ADDRESS <b>Wm Cook-Blight, Inc., 6009 Harford Rd. Balto. 11, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 29 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. Beach</b>	

VS A15 (4)  
15M 9/55

SHIPPED TOP

Cornelius Messick Funeral Home, Bivalve, Maryland

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF CORONER	
13. SIGNATURE OF BURIAL OFFICIAL		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CHURCH OFFICIAL	
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BUREAU V. S.

JAN 30 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00352

## CERTIFICATE OF DEATH

Reg. Dist. No.

362

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>21yr7mthsh4dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1017 North Broadway</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Theresa</b> Last <b>Myers</b>				4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 3, 1896</b>	
9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Charles Richardson</b>				14. MOTHER'S MAIDEN NAME <b>Mariam Pote</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1953</b> , to <b>Jan. 7, 1958</b> , that I last saw the deceased alive on <b>Jan. 7, 1958</b> , and that death occurred at <b>7:45p M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>1-8-58</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook (Mr St Pierre)</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1878		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
MARRIED		1905		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
EDUCATION		SCHOOLING		RECEIVED		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
OCCUPATION		BUSINESS		MANAGER		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		1923		JAN 10		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
PLACE OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
STATE OF DEATH		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND	
COUNTRY OF DEATH		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES	
CAUSE OF DEATH		HEART DISEASE		CORONARY		ARTHEROSCLEROSIS		CORONARY		ARTHEROSCLEROSIS		CORONARY		ARTHEROSCLEROSIS		CORONARY	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
DATE OF REPORT		1923		JAN 10		BALTIMORE		MARYLAND		UNITED STATES		BALTIMORE		MARYLAND		UNITED STATES	
REPORTED BY		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
SIGNATURE		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
TITLE		MANAGER		MANAGER		MANAGER		MANAGER		MANAGER		MANAGER		MANAGER		MANAGER	
ADDRESS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CITY		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND		MARYLAND	
COUNTRY		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES	

BUREAU V. S.

JAN 10 1923

RECEIVED

RECEIVED  
JAN 10 1923  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00353

363

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 6,</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Baltimore, 6, Md.</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4515 Fullerton Ave.</b>				d. STREET ADDRESS <b>4515 Fullerton Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>NEBOHY</b> Last				4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 58</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 29, 1879</b>			
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>Czech.</b>									
13. FATHER'S NAME <b>Frank Joska</b>				14. MOTHER'S MAIDEN NAME <b>Frances Backovsky</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>John Nebohy, husband, above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO <b>HYPERTENSIVE-ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>15 YEARS</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>15 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X DIABETES MELLITUS</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>Nov. 16, 1953</b> , to <b>1.5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8.20</b> , 19 <b>57</b> , and that death occurred at <b>6 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6232 Belvoir Rd, Balt 6, Md</b> DATE SIGNED <b>Jan. 8, 1958</b> ACTUAL SIGNATURE <b>Adam G. Swiss</b> M.D. PHYSICIAN'S NAME (Type) <b>ADAM G. SWISS</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/9/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimunek Funeral Home, Inc.</b> <b>2001-3-5 E. Madison St.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 9 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Debra Smith</b>			

CERTIFICATE OF DEATH

REG. NO. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. MARITAL STATUS		8. OCCUPATION		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		1928		MEMPHIS, TENN.		SINGLE		CLOCK REPAIRER		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH		16. SEX OF DECEASED		17. AGE OF DECEASED		18. RACE OF DECEASED		19. MARITAL STATUS OF DECEASED		20. OCCUPATION OF DECEASED		21. CAUSE OF DEATH		22. MANNER OF DEATH		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF REGISTRAR	
MEMPHIS, TENN.		4/4/68		10:00 AM		M		35		W		SINGLE		CLOCK REPAIRER		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED  
 JAN 9 1969  
 BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

364

## CERTIFICATE OF DEATH

Reg. Dist. No.

00354

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pleasant Hill Rd.</u>		d. STREET ADDRESS <u>Western Run Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sallie O.</u> Middle <u>Nelson</u> Last <u>Nelson</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1864</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elihu Cuddy</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Charles Nelson Sparks, Md. R.D.</u>		Address <u>                    </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis - generalized</u> DUE TO (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November, 1957</u> , to <u>January 21, 1958</u> , that I last saw the deceased alive on <u>January 19, 1958</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D.		ADDRESS (Street, city or town, state) <u>Reisterstown, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Clarence E. McWilliams</u>		DATE SIGNED <u>Jan 21, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton, Md. R.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom Pa.</u>	
24a. REC'D BY REGISTRAR <u>JAN 24 1958</u>		24b. REGISTRAR'S SIGNATURE <u>                    </u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1888		BALTIMORE		BALTIMORE		MARYLAND	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH	
Carpenter		High School		Married		Roman Catholic		Heart Disease		Natural		BALTIMORE		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		STATE OF DEATH		COUNTY OF DEATH		TOWNSHIP OF DEATH	
JAN 24 1939		10:30 AM		HOME		BALTIMORE		MARYLAND		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

RECEIVED  
JAN 24 1939  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

365

## CERTIFICATE OF DEATH

Reg. Dist. No.

00355

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>186 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>434 S. Bond Street</b>			
3. NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>(NMT)</b> Last <b>NOVAK</b>				4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>9/9/86</b>		9. AGE (In years last birthday) <b>71</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Army</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph M. Novak</b>				14. MOTHER'S MAIDEN NAME <b>Mary (Maiden Name -unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Clin.Rec.Vets.Admin.Hospital,Ft.Howard,Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LAENNEC'S CIRRHOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that VA attended the deceased from <b>July 9</b> , 19 <b>57</b> , to <b>January 11</b> , 19 <b>58</b> , and that death occurred at <b>9:20A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald B. Mark</b>				ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Md.</b>		DATE SIGNED <b>1/11/58</b>	
PHYSICIAN'S NAME (Type) <b>DONALD B. MARK, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/15/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. S. Fialkowski</b>				ADDRESS <b>2007 Eastern Ave</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 14 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W.S. Fialkowski</b>			

VS A15 (4)  
ISM 9/55

W.S. Fialkowski, 2007 Eastern Ave, Balto. 3A, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JAN 14 1933

RECEIVED

## 366 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fort Howard</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Fort Howard Vet. Hospital</i>		d. STREET ADDRESS <i>1203 Lakeside Avenue</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. William N. Parr</i>		4. DATE OF DEATH Month Day Year <i>January 27th 1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 10, 1896</i>
9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retail Sales Tax Division</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	11. BIRTHPLACE (State or foreign country) <i>USA</i>
13. FATHER'S NAME <i>Nicholas Parr</i>		14. MOTHER'S MAIDEN NAME <i>Magdalena</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>W.W.1</i>	
17. INFORMANT <i>Mrs. Marie K. Parr</i>		Address <i>1203 Lakeside Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-Sclerotic Cardio Vas.</i> 422.1 DUE TO (b) <i>Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cirrhosis of Liver (Laennec)</i> INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>M. B. Davis</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>M. B. Davis M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/31/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>W. J. Beach</i>		24b. REGISTRAR'S SIGNATURE <i>W. J. Beach</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH NO. _____ COUNTY _____		DISTRICT _____ CITY _____	
NAME OF DECEASED _____ SEX _____ AGE _____		OCCUPATION _____ MARITAL STATUS _____	
PLACE OF BIRTH _____ DATE OF BIRTH _____		PLACE OF DEATH _____ DATE OF DEATH _____	
CAUSE OF DEATH _____ MANNER OF DEATH _____		MEDICAL HISTORY _____ PRESENT ILLNESS _____	
PHYSICIAN'S SIGNATURE _____ DATE _____		MEDICAL EXAMINER'S SIGNATURE _____ DATE _____	
CORONER'S SIGNATURE _____ DATE _____		JURY SIGNATURE _____ DATE _____	
BURIAL PLACE _____ DATE OF BURIAL _____		REMARKS _____ _____	

RECEIVED  
JAN 30 1953  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

367

CERTIFICATE OF DEATH

Reg. Dist. **00357**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3401.4 ✓	
c. LENGTH OF STAY IN 1b <u>8 mo</u>		d. STREET ADDRESS <u>3717 McTavish</u> 29	
3. NAME OF DECEASED (Type or print) <u>ELLA MAY PERRY</u> First Middle Last		4. DATE OF DEATH <u>Jan 7</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 6-1867</u> 1867 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>None</u>	
13. FATHER'S NAME <u>Charles Bass</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Marie D. Schmale</u> Address <u>3717 McTavish Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491x BRONCHOPNEUMONIA - Bilateral</u> DUE TO (b) <u>3 DAYS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>senility</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/30</u> , 19 <u>50</u> , to <u>JANUARY 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JANUARY 6</u> , 19 <u>58</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Melvin N. Burden</u> M.D. <u>5000 BALTIMORE NATIONAL PIKE</u>		DATE SIGNED <u>1/7/58</u>	
PHYSICIAN'S NAME (Type) <u>MELVIN N. BURDEN</u>		<u>BALTIMORE 29 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 10-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Neufel</u> ADDRESS <u>5311 Edmondson Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>	



BUREAU V. B.

1958 6 JAN

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

368

CERTIFICATE OF DEATH

00358

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>902 Kingston Road</u>				d. STREET ADDRESS <u>902 Kingston Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>JOSEPH</u> Last <u>PETERS</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9, 1896</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mfg. Agent.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John George Peters</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Owens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mrs Catherine M. Peters</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 9</u> , 19 <u>58</u> , to <u>Jan 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/19/58</u> , 19 <u>58</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>F.M. Dugan</u> M.D.							
PHYSICIAN'S NAME (Type) <u>F.M. DUGAN</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 22, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co. 4905 York Rd.</u>				24a. REC'D BY REGISTRAR <u>JAN 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

1-10-1938

1. NAME OF DECEASED CHARLES J. BROWN		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 1903	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Salesman	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1915	
9. NAME OF SPOUSE Mary Jane Brown		10. PLACE OF MARRIAGE BALTIMORE, MARYLAND	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home	
13. DATE OF DEATH Jan 21 1938		14. TIME OF DEATH 10:30 AM	
15. SIGNATURE OF PHYSICIAN J. H. Smith		16. SIGNATURE OF WITNESSES J. H. Smith, J. K. Jones	
17. SIGNATURE OF DECEASED Charles J. Brown		18. SIGNATURE OF NEAREST RELATIVE Mary Jane Brown	
19. SIGNATURE OF REGISTRAR J. H. Smith		20. SIGNATURE OF CLERK J. K. Jones	

BUREAU V. S.

JAN 21 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G225 2-10-58 et

00359

212

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Halethorpe, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1406 Avon Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Mary</u> Last <u>Pflaum</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>27</u> Year <u>1958.</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 14-1885</u>
9. AGE (In years last birthday) yrs. <u>72 3/4</u>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Seiglein</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Leiler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>//</u>		16. SOCIAL SECURITY NO. <u>111111</u>	
17. INFORMANT <u>John Pflaum</u>		Address <u>1406 Avon Court</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Asthenoschistosis C.V.D.</u> DUE TO <u>Cerebral Thrombosis</u> DUE TO <u>Hemiparesis (R)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/26</u> , 19 <u>57</u> , to <u>1/27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/26</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street; city or town, state) <u>Halethorpe Md</u> DATE SIGNED <u>1/29/58</u> ACTUAL SIGNATURE <u>John C. Healy</u> M.D. PHYSICIAN'S NAME (Type) <u>John C. Healy</u> <u>1305 Francis Ave, Balto. 27, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 30-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Old Balto, National</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Ave. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>5646 Carville Ave.</u>		24. REC'D BY REGISTRAR DATE <u>FEB 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Carville</u>			

BUREAU V. S.

369

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>House in the Pines / 1650 Rusting Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>J.</u> Last <u>Powell</u>				4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 22, 1866</u>	
9. AGE (In years last birthday) <u>91</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Lawrence Co., Pennsy.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Samuel C. Easton</u>			
14. MOTHER'S MAIDEN NAME <u>Julia Foltz</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mr. Ralph E. Powell</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infirmities of age</u> DUE TO <u>5 1/2 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio Sclerosis</u> DUE TO <u>10 yrs</u> (c) <u>Chronic Myocarditis</u> DUE TO <u>2 mo</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>July 1955</u> to <u>Jan 3, 1958</u> , that I last saw the deceased alive on <u>Jan 2, 1958</u> , and that death occurred at <u>1:00 P.</u> M, from the causes and on the date stated above.			
21. ACTUAL SIGNATURE <u>B B Brumbaugh</u> M.D.				21. ADDRESS (Street, city or town, state) <u>5609 Main St</u>			
21. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>				21. DATE SIGNED <u>1/4/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey, Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. D. Singleton</u>				23. ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

PLACE OF BIRTH _____		DATE OF BIRTH _____	
SEX _____		RACE _____	
OCCUPATION _____		CAUSE OF DEATH _____	
PLACE OF DEATH _____		DATE OF DEATH _____	
NAME OF DECEASED _____		NAME OF PHYSICIAN _____	
NAME OF FUNERAL HOME _____		NAME OF BURIAL PLACE _____	
NAME OF NEXT OF KIN _____		NAME OF WITNESS _____	
NAME OF REGISTRAR _____		NAME OF CLERK _____	

CRIMINAL RECORDS SECTION

BUREAU V. S.

JAN 7 1958

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

370

CERTIFICATE OF DEATH

Reg. Dist. No.

00361

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>405 Reisterstown Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Conrad</u> Last <u>Purcell</u>		4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John R. Sheehan</u>		14. MOTHER'S MAIDEN NAME <u>Geneva Conrad</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>219-07-2501B</u>	
17. INFORMANT <u>Mr. Charles W. Purcell</u>		Address <u>Pikesville 8, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 446x DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Mitral Insufficiency</u> <u>Nephrosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Nephritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 20, 19 58</u> , to <u>Jan 20, 19 58</u> , that I last saw the deceased alive on <u>Jan 20, 19 58</u> , and that death occurred at <u>9 45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Dalman</u> M.D.		ADDRESS (Street, city or town, state) <u>Pikesville Md. Center</u>	
PHYSICIAN'S NAME (Type) <u>Louis Dalman, Md.</u>		DATE SIGNED <u>1/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>Jan. 23, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Newell</u>		ADDRESS <u>Pikesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		MEDICAL ATTENDANT [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		SEX [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		RELIGION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS MARRIAGES [Faint text]		PREVIOUS DEATHS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF MEDICAL ATTENDANT [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	

RECEIVED  
 JAN 24 1938  
 BUREAU V. 3

213

## CERTIFICATE OF DEATH

00362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>57 Halethorpe</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4411 Ridge Ave.</b>		d. STREET ADDRESS <b>4411 Ridge Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HILDA PURDUM</b>		4. DATE OF DEATH <b>January 8 - 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>July 16-1881</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Radtke</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Grunke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>212-10-2358A</b>	
17. INFORMANT <b>Mrs. Hilda Schwartz--4411 Ridge Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident with left 443x DUE TO Hemiplegia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive CARDIO VASCULAR Disease 6yrs DUE TO Disease</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pulmonary Congestion + Arteriosclerotic Heart</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MARCH 1955</b> , to <b>JANUARY 8, 1958</b> , that I last saw the deceased alive on <b>JANUARY 7, 1958</b> , and that death occurred at <b>5:30 A.M.</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>5000 Old Frederick Road</b>		DATE SIGNED <b>1/9/58</b>	
ACTUAL SIGNATURE <b>Melvin N. Borden</b>		M.D. <b>BALTIMORE NATIONAL PIKE BALTIMORE 29, MD</b>	
PHYSICIAN'S NAME (Type) <b>MELVIN N. BORDEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan:11-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. B. Shippert</b>		ADDRESS <b>1300 Eutaw Pl. 17</b>	
24a. REC'D BY REGISTRAR <b>JAN 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. B. Shippert</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 371 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 Y 01. 4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SHADY NOOK NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROSA L. RHODES</u>		4. DATE OF DEATH <u>JAN. 25, 1958</u>	
5. SEX <u>F.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 19, 1863</u> 9. AGE (In years last birthday) <u>94</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>A.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MATTHEW HARDESTY</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELLEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MISS JULIA M. RHODES, 608 COOKS LANE</u>	
17. INFORMANT <u>MISS JULIA M. RHODES, 608 COOKS LANE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO <u>Arteriosclerotic cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 16, 1955</u> , to <u>January 25, 1958</u> , that I last saw the deceased alive on <u>January 24, 1958</u> , and that death occurred at <u>9:15 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Knipp</u>		ADDRESS (Street, city or town, state) <u>4116 Edmondson Avenue Baltimore 29, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>George A. Knipp, M. D.</u>		DATE SIGNED <u>1/27/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKAE FUNERAL DIR. 4101 EDMONDSON AVE</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>			

VS A15 (4)  
15M (2)

VS A15 (4)  
15M 9/55



CERTIFICATE OF DEATH

571

Form 10-1-18

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JAN 29 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

372

## CERTIFICATE OF DEATH

Reg. Dist. No.

00364

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
5. NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>A.</b> Last <b>RICHTER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>19 58</b>			
6. SEX <b>Male</b>		7. COLOR OR RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>70</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Education</b>		11. BIRTHPLACE (State or foreign country) <b>Austira</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Richter</b>				14. MOTHER'S MAIDEN NAME <b>Marie Kada</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>215-18-6192</b>		17. INFORMANT <b>Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY OCCLUSION</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>9 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260 X</b> <b>DIABETES MELLITUS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 2, 1958, to January 11, 1958</b> and that death occurred at <b>4:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Sol Levinson</b>				M.D. <b>VAH, Fort Howard, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-15-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight Jr</b>				ADDRESS <b>6009 Harford Rd</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 14 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Rev. Smith</b>			

# CERTIFICATE OF DEATH

REG. DIV. 21

<p>1. NAME OF DECEASED                  2. SEX                  3. AGE                  4. DATE OF BIRTH                  5. PLACE OF BIRTH                  6. OCCUPATION                  7. MARITAL STATUS                  8. COLOR                  9. RELIGION                  10. EDUCATION                  11. SERVICE                  12. PLACE OF DEATH                  13. DATE OF DEATH                  14. TIME OF DEATH                  15. CAUSE OF DEATH                  16. MANNER OF DEATH                  17. SIGNATURE OF DECEASED                  18. SIGNATURE OF WITNESSES                  19. SIGNATURE OF CLERK                  20. SIGNATURE OF REGISTRAR</p>		<p>21. NAME OF CLERK                  22. NAME OF REGISTRAR                  23. NAME OF WITNESSES                  24. NAME OF CLERK                  25. NAME OF REGISTRAR                  26. NAME OF WITNESSES                  27. NAME OF CLERK                  28. NAME OF REGISTRAR                  29. NAME OF WITNESSES                  30. NAME OF CLERK                  31. NAME OF REGISTRAR                  32. NAME OF WITNESSES                  33. NAME OF CLERK                  34. NAME OF REGISTRAR                  35. NAME OF WITNESSES                  36. NAME OF CLERK                  37. NAME OF REGISTRAR                  38. NAME OF WITNESSES                  39. NAME OF CLERK                  40. NAME OF REGISTRAR                  41. NAME OF WITNESSES                  42. NAME OF CLERK                  43. NAME OF REGISTRAR                  44. NAME OF WITNESSES                  45. NAME OF CLERK                  46. NAME OF REGISTRAR                  47. NAME OF WITNESSES                  48. NAME OF CLERK                  49. NAME OF REGISTRAR                  50. NAME OF WITNESSES                  51. NAME OF CLERK                  52. NAME OF REGISTRAR                  53. NAME OF WITNESSES                  54. NAME OF CLERK                  55. NAME OF REGISTRAR                  56. NAME OF WITNESSES                  57. NAME OF CLERK                  58. NAME OF REGISTRAR                  59. NAME OF WITNESSES                  60. NAME OF CLERK                  61. NAME OF REGISTRAR                  62. NAME OF WITNESSES                  63. NAME OF CLERK                  64. NAME OF REGISTRAR                  65. NAME OF WITNESSES                  66. NAME OF CLERK                  67. NAME OF REGISTRAR                  68. NAME OF WITNESSES                  69. NAME OF CLERK                  70. NAME OF REGISTRAR                  71. NAME OF WITNESSES                  72. NAME OF CLERK                  73. NAME OF REGISTRAR                  74. NAME OF WITNESSES                  75. NAME OF CLERK                  76. NAME OF REGISTRAR                  77. NAME OF WITNESSES                  78. NAME OF CLERK                  79. NAME OF REGISTRAR                  80. NAME OF WITNESSES                  81. NAME OF CLERK                  82. NAME OF REGISTRAR                  83. NAME OF WITNESSES                  84. NAME OF CLERK                  85. NAME OF REGISTRAR                  86. NAME OF WITNESSES                  87. NAME OF CLERK                  88. NAME OF REGISTRAR                  89. NAME OF WITNESSES                  90. NAME OF CLERK                  91. NAME OF REGISTRAR                  92. NAME OF WITNESSES                  93. NAME OF CLERK                  94. NAME OF REGISTRAR                  95. NAME OF WITNESSES                  96. NAME OF CLERK                  97. NAME OF REGISTRAR                  98. NAME OF WITNESSES                  99. NAME OF CLERK                  100. NAME OF REGISTRAR</p>
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BUREAU V. S.

JAN 14 1938

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00365

373

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glen Arm. Road</u>		d. STREET ADDRESS <u>Glen Arm Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>A.</u> Last <u>Ridlehoover</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>19 58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sgt Agent, R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saluda, South Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sumter L. Ridlehoover</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mr. Jack O. Ridlehoover, Glen Arm. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>10 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage, 1947</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/10</u> , 19 <u>57</u> , to <u>1/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/15</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>Fork, Md.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		DATE SIGNED <u>Fork, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/19/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Plum Branch Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>South Carolina</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Hartford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 20 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Deborah</u>

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MANNER OF DEATH		CAUSE OF DEATH		DISEASE OR INJURY	
WHITE		WHITE		METHODIST		HIGH SCHOOL		Pilot		Suicide		Gunshot wound		Suicide	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APR 4 1968		MEMPHIS		MEMPHIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		PLACE		CITY		STATE		COUNTRY		DATE		PLACE		CITY	
APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APR 4 1968		MEMPHIS		MEMPHIS	

RECEIVED  
JAN 20 1968  
BUREAU V. S.

*James Earl Ray*  
*Victor F. Harrison*  
*April 4, 1968*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 374 CERTIFICATE OF DEATH

00366

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE Where deceased lived. If institution, Residence before admission) a. STATE <u>2108 Kaussey St.</u> b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb <u>5 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>2108 Kaussey St.</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>J.</u> Last <u>RIGGS</u>		4. DATE OF DEATH Month <u>January</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-1878</u> AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. City</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Riggs</u>		14. MOTHER'S MAIDEN NAME <u>Barbara</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>212-10-7482</u>	
17. INFORMANT <u>Miss Mildred Riggs</u> Address <u>4722 Dentford Ave. #29</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of rectum</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>8/2</u> , 1957, to <u>1/18</u> , 1958, that I last saw the deceased alive on <u>1/18</u> , 1958, and that death occurred at <u>8:30</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin Gene Reeves</u>		ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp.</u> DATE SIGNED <u>1/18/58</u>	
PHYSICIAN'S NAME (Type) <u>Edwin GENE REEVES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-22-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	22d. LOCATION (City, town, or county) <u>BALTIMORE</u> (State) <u>MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo R Schweb</u> ADDRESS <u>2101 Frederick Ave</u>		24a. REC'D BY REGISTRAR <u>Jan 20 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Reed</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



# CERTIFICATE OF DEATH

WIN BOND

BUREAU V. S.

JAN 20 1958

RECEIVED



214

## CERTIFICATE OF DEATH

00367

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>				c. LENGTH OF STAY IN 1b <b>4 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1122 Elm Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HELEN A. RIMBACH</b>				4. DATE OF DEATH <b>January 29 19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 21, 1890</b>	
9. AGE (In years lost birthday) <b>67 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sewing Machine Operator -Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Rudolph Junghans</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Schmidt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>216-01-1962</b>		17. INFORMANT <b>Helen M. Waznak</b> Address <b>Arbutus Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Failure</b> DUE TO <b>331x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Vascular Accident</b> DUE TO <b>Hypertension</b> (c) <b>Angina Pectoris</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Angina Pectoris</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-29-58</b> , 19 <b>58</b> , to <b>1-29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-29-58</b> , 19 <b>58</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4605 Edmondson Ave.</b> DATE SIGNED <b>30 Jan 58</b>							
ACTUAL SIGNATURE <b>William J. Bryson</b>				M.D. <b>4605 Edmondson Ave.</b>			
PHYSICIAN'S NAME (Type) <b>William J. Bryson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 1-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. B. Support</b>				ADDRESS <b>1300 Eutaw Pl. 17</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 4 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. B. Support</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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215074

BUREAU V. S.

EB 4 1958

RECEIVED

375

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1mth10dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. STREET ADDRESS <u>1455 Reynolds Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Paul</u> Last <u>Rost</u>				4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1879</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>barber</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Amile Rost</u>				14. MOTHER'S MAIDEN NAME <u>Emma Doering</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 25</u> , 19 <u>57</u> , to <u>Jan. 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 3</u> , 19 <u>58</u> , and that death occurred at <u>11:30p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>1-3-58</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/6/1958</u>		<u>Cedar Hill Cemetery</u>		<u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles F. Piller</u>				ADDRESS <u>1501 E. Fort Ave</u>		24a. REC'D BY REGISTRAR DATE <u>1/6/58</u>	
						24b. REGISTRAR'S SIGNATURE <u>R. H. Hedrick</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form D.H. 100

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. COLOR [Faint text]		9. RELIGION [Faint text]		10. EDUCATION [Faint text]		11. SOCIAL CLASS [Faint text]		12. PLACE OF DEATH [Faint text]	
13. CAUSE OF DEATH [Faint text]		14. MANNER OF DEATH [Faint text]		15. PERIOD OF ILLNESS [Faint text]		16. TIME OF DEATH [Faint text]		17. SIGNATURE OF PHYSICIAN [Faint text]		18. SIGNATURE OF REGISTRAR [Faint text]	
19. SIGNATURE OF WITNESS [Faint text]		20. SIGNATURE OF DECEASED [Faint text]		21. SIGNATURE OF NEXT OF KIN [Faint text]		22. SIGNATURE OF CLERGYMAN [Faint text]		23. SIGNATURE OF MINISTER [Faint text]		24. SIGNATURE OF CHURCH [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF NEXT OF KIN [Faint text]		27. SIGNATURE OF CLERGYMAN [Faint text]		28. SIGNATURE OF MINISTER [Faint text]		29. SIGNATURE OF CHURCH [Faint text]		30. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. S.

JAN 7 1952

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00369

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balto.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper</u> c. LENGTH OF STAY IN lb <u>9 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mt Zion Rd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper</u> d. STREET ADDRESS <u>Mt. Zion Rd.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>WOS. NELSON RUBY</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>Jan 19 1958</u> Month Day Year											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug 20, 1883</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Bar tender</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Tavern</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Carroll Co, Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Amos N. Ruby</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah (last name unknown)</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No.</u>				<b>16. SOCIAL SECURITY NO.</b> <u>213-18-3355</u>				<b>17. INFORMANT</b> <u>None</u> Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis &amp; arteriosclerosis &amp; decompensation</u> DUE TO (b) <u>7 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>7 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>															
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>None</u>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>None</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>None</u>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>None</u>		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>D. D. Caples</u>						<b>DATE SIGNED</b> <u>1-19-58</u>									
<b>EXAMINER'S NAME (Type)</b> <u>D. D. CAPLES</u>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Jan. 22, 1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Grace Methodist Cemetery</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Cockeysville, Maryland</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John Burns Sons</u>						<b>ADDRESS</b> <u>Towson, Md.</u>									
<b>24a. REC'D BY REGISTRAR</b> <u>JAN 22 '58</u>						<b>24b. REGISTRAR'S SIGNATURE</b> <u>Alb. Lewis</u>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00370

377

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>6 Days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>			d. STREET ADDRESS <b>10 East Poultney Street</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>MARION</b> Middle <b>W.</b> Last <b>RUSSELL</b>			4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 17, 1893</b>		9. AGE (In years last birthday) yrs. <b>64</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>William Russell</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Bletz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA BOTH RIGHT AND LEFT LOWER LOBES</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. _____ Month, Day, Year _____ <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from <b>January 10</b> , 19 <b>58</b> , to <b>January 16</b> , 19 <b>58</b> , and that death occurred at <b>1:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Chien Wet Lan</b> M.D. <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b> <b>1/16/58</b> PHYSICIAN'S NAME (Type) <b>CHIEN WET LAN, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-20-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>	
22d. LOCATION (City, town, or county) _____ (State) _____					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 11, Md.</b>		ADDRESS <b>JAN 20 '58</b>		24a. REC'D BY REGISTRAR <b>24b. REGISTRAR'S SIGNATURE</b>	

CERTIFICATE OF BIRTH

NAME OF CHILD		DATE OF BIRTH		PLACE OF BIRTH	
MARY ANN		JAN 21 1958		BALTIMORE, MARYLAND	
FATHER'S NAME		MOTHER'S NAME		MARITAL STATUS	
JOHN J. SMITH		MARY J. SMITH		MARRIED	
FATHER'S ADDRESS		MOTHER'S ADDRESS		DATE OF MARRIAGE	
1234 E. MAIN ST.		1234 E. MAIN ST.		JAN 15 1955	
CITY		COUNTY		STATE	
BALTIMORE		BALTIMORE		MARYLAND	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		EDUCATION OF FATHER	
LABORER		HOUSEWIFE		HIGH SCHOOL	
FATHER'S EDUCATION		MOTHER'S EDUCATION		EDUCATION OF MOTHER	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
FATHER'S RELIGION		MOTHER'S RELIGION		RELIGION OF CHILD	
CATHOLIC		CATHOLIC		CATHOLIC	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE		DATE OF REGISTRATION	
[Signature]		[Signature]		JAN 21 1958	
FATHER'S ADDRESS		MOTHER'S ADDRESS		DATE OF BIRTH	
1234 E. MAIN ST.		1234 E. MAIN ST.		JAN 21 1958	
CITY		COUNTY		STATE	
BALTIMORE		BALTIMORE		MARYLAND	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		EDUCATION OF FATHER	
LABORER		HOUSEWIFE		HIGH SCHOOL	
FATHER'S EDUCATION		MOTHER'S EDUCATION		EDUCATION OF MOTHER	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
FATHER'S RELIGION		MOTHER'S RELIGION		RELIGION OF CHILD	
CATHOLIC		CATHOLIC		CATHOLIC	

BUREAU V. 3

JAN 21 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00371

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abutux</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 abutux</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1208 Elm Ridge ar</u>		d. STREET ADDRESS <u>1208 Elm Ridge ar</u>	
3. NAME OF DECEASED (Type or print) <u>Fred. Joseph Saffran</u>		4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19 1905</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>7</u> Hours <u>52</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chapman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brook</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Saffran</u>		14. MOTHER'S MAIDEN NAME <u>Mary Weiler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-5756</u>	
17. INFORMANT <u>Emma Saffran</u>		Address <u>Balto md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-29-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George F. Schwab</u>		ADDRESS <u>2101 Frederick Ave</u>	
24a. REC'D BY REGISTRAR <u>JAN 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

BOREAU V. S.

1998

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DECEMBER

BUREAU V. S.

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RECEIVED

## CERTIFICATE OF DEATH

00372

Reg. Dist. No.

378

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>29 dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Herman</b> Middle <b>William</b> Last <b>Sander</b>				4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>19 58</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 5, 1883</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>Herman Sander</b>				14. MOTHER'S MAIDEN NAME <b>Phillipina</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peri-renal abscess and pyelonephritis</b> <b>602x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrolithiasis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 30</b> , 19 <b>57</b> , to <b>Jan. 8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan. 8</b> , 19 <b>58</b> , and that death occurred at <b>7:10a. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b> <b>1-8-58</b> PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>1-11-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Switland Ind</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Mattingly</b>				ADDRESS <b>131-11-58</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 10 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Robert A. Mattingly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>Male</u>	
3. AGE <u>45</u>		4. DATE OF BIRTH <u>Jan 15, 1914</u>	
5. PLACE OF BIRTH <u>St. Louis, Mo.</u>		6. OCCUPATION <u>Engineer</u>	
7. MARITAL STATUS <u>Married</u>		8. DATE OF MARRIAGE <u>Aug 10, 1938</u>	
9. NAME OF SPOUSE <u>Mary E. Smith</u>		10. DATE OF DEATH <u>Jan 10, 1959</u>	
11. PLACE OF DEATH <u>Home</u>		12. CAUSE OF DEATH <u>Heart Disease</u>	
13. MEDICAL HISTORY <u>None</u>		14. PRESENT ILLNESS <u>None</u>	
15. SIGNATURE OF PHYSICIAN <u>[Signature]</u>		16. SIGNATURE OF REGISTRAR <u>[Signature]</u>	
17. DATE OF SIGNATURE <u>Jan 10, 1959</u>		18. PLACE OF SIGNATURE <u>Baltimore, Md.</u>	

RECEIVED  
JAN 10 1959  
BUREAU V. S.

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE RETURNED TO THE PHYSICIAN WHO ISSUED IT, OR TO THE PERSON WHO OBTAINED IT, FOR THE PURPOSES OF THE MORTUARY RECORDS. IT IS TO BE DESTROYED AFTER THE EXPIRATION OF THE TERM OF YEARS SPECIFIED IN THE MORTUARY RECORDS. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. FOR THE PURPOSES OF THE MORTUARY RECORDS.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

003

379

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="margin-left: 100px;"><b>Baltimore</b></span> <span style="margin-left: 100px;"><b>MARYLAND</b></span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional: Residence before admission) a. STATE <span style="margin-left: 100px;"><b>Maryland</b></span> <span style="margin-left: 100px;">b. COUNTY</span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;"><b>Fort Howard</b></span>			c. LENGTH OF STAY IN 1b <span style="margin-left: 100px;"><b>116 days</b></span>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;"><b>Baltimore</b></span> <span style="margin-left: 100px;"><b>3401-4</b></span>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="margin-left: 100px;"><b>Veterans Administration Hospital</b></span>				d. STREET ADDRESS <span style="margin-left: 100px;"><b>1006 N. Stricker Street</b></span>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="margin-left: 100px;"><b>THOMAS</b></span> Middle <span style="margin-left: 100px;"><b>S</b></span> Last <span style="margin-left: 100px;"><b>SAVOY</b></span>				<b>4. DATE OF DEATH</b> Month <span style="margin-left: 100px;"><b>January</b></span> Day <span style="margin-left: 100px;"><b>10</b></span> Year <span style="margin-left: 100px;"><b>19 58</b></span>					
<b>5. SEX</b> <span style="margin-left: 100px;"><b>Male</b></span>		<b>6. COLOR OR RACE</b> <span style="margin-left: 100px;"><b>Colored</b></span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="margin-left: 100px;"><b>7/20/95</b></span>		<b>9. AGE</b> (In years last birthday) <span style="margin-left: 100px;"><b>62</b></span> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="margin-left: 100px;"><b>Laborer</b></span>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="margin-left: 100px;"><b>unknown</b></span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="margin-left: 100px;"><b>Maryland</b></span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="margin-left: 100px;"><b>U.S.A.</b></span>	
<b>13. FATHER'S NAME</b> <span style="margin-left: 100px;"><b>Thomas Savoy</b></span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="margin-left: 100px;"><b>Maria Pinder</b></span>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="margin-left: 100px;">(If yes, give war or dates of service)</span> Yes <input checked="" type="checkbox"/> <span style="margin-left: 100px;"><b>WWI</b></span>		<b>16. SOCIAL SECURITY NO.</b> <span style="margin-left: 100px;"><b>218-10-7057</b></span>		<b>17. INFORMANT</b> Address <span style="margin-left: 100px;"><b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b></span>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="margin-left: 100px;"><b>BRONCHOGENIC CARCINOMA</b></span> <span style="margin-left: 100px;"><b>162.1</b></span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <span style="margin-left: 100px;"><b>2. PADGETT'S DISEASE</b></span> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <span style="margin-left: 100px;"><b>1 YR</b></span>  <span style="margin-left: 100px;"><b>UNKNOWN</b></span>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <span style="margin-left: 100px;"><b>19</b></span> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that</b> <del>He</del> <b>she</b> attended the deceased from <b>September 16, 1957</b> , to <b>January 10, 1958</b> , and that death occurred at <b>7:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <span style="margin-left: 100px;"><b>VAH FORT HOWARD, MD.</b></span> DATE SIGNED <span style="margin-left: 100px;"><b>1/10/58</b></span>									
ACTUAL SIGNATURE <span style="margin-left: 100px;"><i>Chien Wei Lan</i></span> M.D.				PHYSICIAN'S NAME (Type) <span style="margin-left: 100px;"><b>CHIEN WEI LAN, M. D.</b></span>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="margin-left: 100px;"><b>Burial</b></span>		<b>22b. DATE THEREOF</b> <span style="margin-left: 100px;"><b>1-15-58</b></span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="margin-left: 100px;"><b>Baltimore National</b></span>		<b>22d. LOCATION</b> (City, town, or county) (State) <span style="margin-left: 100px;"><b>Balto., Md.</b></span>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="margin-left: 100px;"><i>Charles R. Law</i></span>				ADDRESS		<b>24a. REC'D BY REGISTRAR</b> DATE <span style="margin-left: 100px;"><b>JAN 14 '58</b></span>		<b>24b. REGISTRAR'S SIGNATURE</b> <span style="margin-left: 100px;"><i>Dee...</i></span>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

JAN 14 1953

RECEIVED

380 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO. COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Augsburg Home</u>		d. STREET ADDRESS <u>3531 Old Frederick Rd.</u> <u>18811 CLAYMOUNT RD.</u>	
3. NAME OF DECEASED (Type or print) <u>CAROLINE E. SCANLON</u>		4. DATE OF DEATH <u>JAN. 1, 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 31, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George H. Eck</u>		14. MOTHER'S MAIDEN NAME <u>LIZETTA Esrich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. GERHARDT MERKEL</u>		Address <u>3531 Old Fred. Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> <u>096.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal Virus Infection.</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 days</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4914</u> <u>Paralysis Cerebralis</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1, 1958</u> , to <u>Jan. 1, 1958</u> , that I last saw the deceased alive on <u>Dec. 31, 1957</u> , and that death occurred at <u>4108 Liberty Hts. Ave.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		DATE SIGNED <u>1/3/58</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		<u>4108 Liberty Hts. Balto. Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>JAN. 4, 1958</u>	<u>London Park Cem.</u>	<u>BALTO. MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman Schwab</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	
24a. REC'D BY REGISTRAR <u>JAN 6 1958</u>		24b. REGISTRAR'S SIGNATURE <u>U. H. Hedrick</u>	

BUREAU V. S.

AN 5 1959

RECEIVED

381

## CERTIFICATE OF DEATH

00375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b> c. LENGTH OF STAY IN 1b <b>29 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock, Maryland</b> d. STREET ADDRESS <b>218-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Evelyn</b> Middle <b>Susan</b> Last <b>Schaeffer</b>		4. DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/13</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>44</b>	IF UNDER 24 HRS. Days <b>44</b> Hours <b>44</b> Min. <b>44</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
13. FATHER'S NAME <b>Charles S. Schaeffer (deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Estella Taite Spidel (deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Rosewood Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Aspiration pneumonia</b> 353.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Epilepsy and Idiocy, congenital</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>1:00 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1/31/58</b>			
ACTUAL SIGNATURE <b>Rich. Ginderberg (Physician)</b> M.D.		PHYSICIAN'S NAME (Type) <b>Rich. Ginderberg (Physician)</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>Feb. 4/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE		24. REGISTRAR'S SIGNATURE <b>W. J. French</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

RECEIVED  
FEB. 6 1958  
BUREAU Y. 3



## 382 CERTIFICATE OF DEATH

Reg. Dist. No.

00376

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>116 Forest Drive</b>				d. STREET ADDRESS <b>116 Forest Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>J.</b> Middle <b>FRANK</b> Last <b>SCHAFER</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>17,</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 13, 1880</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice Pres. (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hubbs &amp; Corning Co</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Schafer</b>				14. MOTHER'S MAIDEN NAME <b>Mary -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mr. J. Frederick Schafer - 106 Balto. Annapolis Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Fibrosis</b> DUE TO (c) <b>Arterio sclerosis (cor Pulmonale)</b>						INTERVAL BETWEEN ONSET AND DEATH <b>54 years</b> <b>4 years</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 19 30</b> , to <b>Jan 17 19 58</b> that I last saw the deceased alive on <b>Jan 16 19 58</b> , and that death occurred at <b>4:17</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wetherbee Ford</b>				ADDRESS (Street, city or town, state) <b>1118 St. Paul St - Balto.</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>Wetherbee Ford</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/20/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tinkner &amp; Sons - Balto</b>				ADDRESS <b>17 1/2</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Wetherbee Ford</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

RESIDENCE

CAUSE OF DEATH

BUREAU V. S.

JAN 21 1938

RECEIVED

## CERTIFICATE OF DEATH

00377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7014 Kenleigh Rd.</u>		d. STREET ADDRESS <u>7014 Kenleigh Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Schaffer</u>		4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>@ Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Mullen</u>		14. MOTHER'S MAIDEN NAME <u>Bridget</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Bessie M. Barry</u>		Address <u>7014 Kenleigh Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Starvation acidosis</u> <u>151x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pernicious vomiting and obstruction</u> DUE TO (c) <u>Carcinoma of stomach</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-6 wks</u> <u>1 year.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 11, 1955</u> , to <u>Jan 11, 1958</u> , that I last saw the deceased alive on <u>Jan 11, 1958</u> , and that death occurred at <u>9:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore J. Graziano</u> M.D.		ADDRESS (Street, city or town, state) <u>2802 Harford Rd</u> DATE SIGNED <u>1/13/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc.</u>		ADDRESS <u>5305 Harford Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AN 14 1958

BUREAU V. 3

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

## 384 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>25 EGGES LANE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>E.</u> Last <u>SCHAIBLE</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEP. 3, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED GRAVE DIGGER, LOUDON PARK CEM.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>			
11. BIRTHPLACE (State or foreign country) <u>USA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>----- SCHAIBLE</u>				14. MOTHER'S MAIDEN NAME <u>Do not know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MRS ANNA E. SCHAIBLE</u> <u>25 EGGES LANE, CATONSVILLE 28, MD.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive, arteriosclerotic</u> DUE TO (c) <u>cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>20 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Sept 11</u> , 19 <u>57</u> , to <u>Jan 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>58</u> , and that death occurred at <u>10:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Rowe</u>				DATE SIGNED <u>1 Jan 58</u>			
PHYSICIAN'S NAME (Type) <u>James E. Rowe M.D.</u>				ADDRESS (Street, city or town, state) <u>715 Frederick Ave. 28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUNERAL DIR, 4101 E MONDSON</u>				24a. REC'D BY REGISTRAR <u>JAN 3 1958</u>			
24b. REGISTRAR'S SIGNATURE <u>U. M. M. M. M.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1953

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

385

## CERTIFICATE OF DEATH

00379

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> <i>3001-4</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr5mths20dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Schaub</b> Last <b>Schaub</b>				4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1883 10/16 74?</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Patrick Gragan</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan. 7</b> , 19 <b>58</b> , to <b>Jan. 11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan. 11</b> , 19 <b>58</b> , and that death occurred at <b>8:35 p.m.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachler</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 1-13-58</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>				<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/15/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, INC.</b>				ADDRESS <b>715 Light St.</b>		24a. REC'D BY REGISTRAR <b>JAN 14 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>Alfred</i>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BURIAL [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF WITNESSES [Faint text]	
NAME OF PHYSICIAN [Faint text]		NAME OF CORONER [Faint text]		NAME OF WITNESSES [Faint text]	
ADDRESS OF PHYSICIAN [Faint text]		ADDRESS OF CORONER [Faint text]		ADDRESS OF WITNESSES [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF NEXT OF KIN [Faint text]		SIGNATURE OF OTHER RELATIVES [Faint text]	
NAME OF DECEASED [Faint text]		NAME OF NEXT OF KIN [Faint text]		NAME OF OTHER RELATIVES [Faint text]	
ADDRESS OF DECEASED [Faint text]		ADDRESS OF NEXT OF KIN [Faint text]		ADDRESS OF OTHER RELATIVES [Faint text]	

BUREAU V. S.

JAN 14 1958

RECEIVED

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased. It is to be filed in the office of the State Department of Health, Baltimore, Maryland. The certificate is to be filled out in duplicate. One copy is to be filed in the office of the State Department of Health, Baltimore, Maryland. The other copy is to be filed in the office of the local health department or coroner's office. The certificate is to be filled out in duplicate. One copy is to be filed in the office of the State Department of Health, Baltimore, Maryland. The other copy is to be filed in the office of the local health department or coroner's office.

## 386 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Balto, City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cowwago Mills</i>		c. LENGTH OF STAY IN 1b <i>5 mos 26 ds.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood State Pr. School</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> <i>3Y01-4</i>	
f. STREET ADDRESS <i>2227 North St. Paul Street</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>James</i> Last <i>Schmidt</i>		4. DATE OF DEATH Month <i>January</i> Day <i>25</i> Year <i>1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-6-54</i>
9. AGE (In years last birthday) <i>3</i>		IF UNDER 1 YEAR Months <i>3</i> Days <i>1</i> Hours <i>1</i> Min. <i>1</i>	IF UNDER 24 HRS. Months <i>3</i> Days <i>1</i> Hours <i>1</i> Min. <i>1</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Joseph Greenleaf Schmidt</i>		14. MOTHER'S MAIDEN NAME <i>Mary Martha Wilson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital Records</i>		Address <i>Cowwago Mills, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration of food</i> DUE TO <i>571.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Mild gastroenteritis, nature undetermined</i> DUE TO <i>Mongeloid idiocy</i> (c) <i>Mongeloid idiocy</i>			INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>1 week</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7-29-</i> , 19 <i>57</i> , to <i>1-25-</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>1-25-</i> , 19 <i>58</i> , and that death occurred at <i>9:20 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Rich. E. Lindenberg (Pathol.)</i> M.D.			
PHYSICIAN'S NAME (Type) <i>Rich. E. Lindenberg (Pathologist)</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>Jan. 28/58</i>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Rosewood Cemetery</i>		<i>Cowwago Mills Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Elmer Amos Ruststrous md</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>JAN 30 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. E. Beach</i>	

MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

FORM 10 - CERTIFICATE OF DEATH

BUREAU V. S.

JAN 30 1958

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

387

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4mths4dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3V0114	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>2518 Loyola Southway #15</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Schmukler</b> Last <b>Schmukler</b>		4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1895</b>
9. AGE (In years lost birthday) yrs. <b>62</b>		IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min. <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>grocer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery store</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Russia</b>	
13. FATHER'S NAME <b>Max Schmukler</b>		14. MOTHER'S MAIDEN NAME <b>Adele Glass</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>G/loblastoma of Rt. Temporal lobe</b> <b>193.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>193.0</b> DUE TO (c) <b>193.0</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonitis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gastrointestinal bleeding of unknown cause</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 20, 1957</b> , to <b>1-3-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-3-</b> , 19 <b>58</b> , and that death occurred at <b>11:08 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>1-3-58</b>			
ACTUAL SIGNATURE <b>C. Eugene Watermann</b> M.D.		DATE SIGNED <b>1-3-58</b>	
PHYSICIAN'S NAME (Type) <b>C. Eugene Watermann</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-6-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>My Carmel</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc</b>		ADDRESS <b>2100 Euteria Pl</b>	
24a. REC'D BY REGISTRAR <b>JAN 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1961 2 NY

RECEIVED



## 388 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>33 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Unknown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>Unknown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b> <sup>First</sup> <b>C.</b> <sup>Middle</sup> <b>Schwab</b> <sup>Last</sup>		4. DATE OF DEATH Month <b>1</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1888</b> <b>11-19-1888 (?)</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b> <b>John Schwab</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b> <b>CAROLINE KOLB</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerosis, generalized</b> DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Inanition due to chronic mental illness</b>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1955</b> , to <b>Jan. 20, 1958</b> , that I last saw the deceased alive on <b>Jan. 20, 1958</b> , and that death occurred at <b>7:10p. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Stella Wachsler</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>1-20-58</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-23-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK Cem.</b>	
22d. LOCATION (City, town, or county) <b>BALTIMORE</b>		(State) <b>MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Truman Schwab</b>		ADDRESS <b>3512 Frederick Ave. (29)</b>		24a. REC'D BY REGISTRAR <b>JAN 23 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Albert Seuch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 23 1938

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

389 CERTIFICATE OF DEATH

Reg. Dist. No. 00383

1. PLACE OF DEATH o. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> 7			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <b>5 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2653 Purnell Drive</b>				d. STREET ADDRESS <b>2653 Purnell Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Edward</b> Last <b>Schwarzkopf</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>25</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 22, 1894</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b>3</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bendix Corp</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles J. Schwarzkopf</b>				14. MOTHER'S MAIDEN NAME <b>Veronica Reis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1-16-13 WWI</b>		17. INFORMANT Address <b>Mrs Mary Schwarzkopf, 2653 Purnell Drive</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ames trophic Suture</b> <b>356.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Sclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 1956</b> , 19____, to <b>Jan 25, 1958</b> , that I last saw the deceased alive on <b>Jan 24 1958</b> , 19____, and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3033 W North Ave Baltimore</b> DATE SIGNED <b>Paul Byerly</b>							
ACTUAL SIGNATURE <b>M. Paul Byerly</b> M.D.							
PHYSICIAN'S NAME (Type) <b>M. Paul Byerly</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-29-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>David R. Martin, 1902 Eutaw Place</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Deborah</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		DATE OF DEATH	
MANNER OF DEATH		DATE OF DEATH	
AGE		DATE OF DEATH	
SEX		DATE OF DEATH	
RACE		DATE OF DEATH	
RELIGION		DATE OF DEATH	
EDUCATION		DATE OF DEATH	
OCCUPATION		DATE OF DEATH	
MARRIAGE		DATE OF DEATH	
CHILDREN		DATE OF DEATH	
SIBLINGS		DATE OF DEATH	
PARENTS		DATE OF DEATH	
GRANDPARENTS		DATE OF DEATH	
OTHER RELATIVES		DATE OF DEATH	
SOCIAL HISTORY		DATE OF DEATH	
MEDICAL HISTORY		DATE OF DEATH	
SURGICAL HISTORY		DATE OF DEATH	
HISTORICAL DATA		DATE OF DEATH	
PHYSICAL EXAMINATION		DATE OF DEATH	
LABORATORY EXAMINATIONS		DATE OF DEATH	
PATHOLOGICAL FINDINGS		DATE OF DEATH	
FINAL DIAGNOSIS		DATE OF DEATH	
CERTIFICATE OF DEATH		DATE OF DEATH	

BUREAU V. S.

JAN 30 1953

RECEIVED

Reg. Dist. No. 00384

1. PLACE OF DEATH <b>Rosewood State Training School</b> o. COUNTY <b>Baltimore</b> MARYLAND										2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>																													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>										c. LENGTH OF STAY IN lb <b>3 years</b>																													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>										d. STREET ADDRESS <b>Abingdon, Maryland 128-2</b>																													
3. NAME OF DECEASED (Type or print) First <b>Penelope</b> Middle <b>Lee</b> Last <b>Sewell</b>										4. DATE OF DEATH Month <b>1</b> Day <b>21</b> Year <b>19 58</b>																													
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>4/19/54</b>			9. AGE (In years last birthday) <b>3 yrs.</b>			IF UNDER 1 YEAR Months Days Hours Min.			IF UNDER 24 HRS.																					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10b. KIND OF BUSINESS OR INDUSTRY										11. BIRTHPLACE (State or foreign country) <b>Maryland</b>										12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>William K. Sewell</b>															14. MOTHER'S MAIDEN NAME <b>Catherine Virginia Schueler</b>																								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>										16. SOCIAL SECURITY NO. <b>Rosewood Records</b>										17. INFORMANT <b>Rosewood Records</b>										Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> <b>325.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mongolism</b> DUE TO (c) _____																									INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>since birth</b>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>																									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>										20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)																			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>10:10a.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Rosewood Training School</b> DATE SIGNED <b>1/21/58</b> ACTUAL SIGNATURE <b>Ellis J. Maiglen</b> M.D. PHYSICIAN'S NAME (Type) <b>Owings Mills Maryland</b>																																							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										22b. DATE THEREOF <b>Jan. 23, 1958</b>					22c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Memorial</b>					22d. LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Md.</b>																			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McCune</b>															ADDRESS <b>Abingdon Md.</b>										24a. REC'D BY REGISTRAR DATE <b>JAN 27 '58</b>					24b. REGISTRAR'S SIGNATURE <b>Paul</b>									

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is divided into several horizontal sections with labels for each field.

BUREAU V. S.

JAN 27 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

391

## CERTIFICATE OF DEATH

Reg. Dist. No. 00385

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>16 X - 2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>SHERIFF</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DEWEY FITZHUGH SHAW</b>		4. DATE OF DEATH Month Day Year <b>1 30 1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-7-99</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>BROOK SHAW</b>		14. MOTHER'S MAIDEN NAME <b>MARY BERRY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>20 YRS AGO</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>RHEUMATOID ARTHRITIS</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-28-1958</b> to <b>1-30-1958</b> , that I last saw the deceased alive on <b>1-30-1958</b> , and that death occurred at <b>5:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. <b>Mt. Wilson, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/1/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Addison Chapel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Seat Pleasant Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George L. Schmitt</b>		ADDRESS <b>2101 Kendrick Ave</b>	
24a. REC'D BY REGISTRAR <b>FEB 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Schmitt</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. RACE White		5. DATE OF DEATH Feb 3 1958		6. PLACE OF DEATH Home	
7. OCCUPATION Retired		8. MARITAL STATUS Married		9. BIRTH DATE 1893		10. BIRTH PLACE Maryland		11. US BIRTH Yes		12. FOREIGN BIRTH No	
13. CAUSE OF DEATH Heart Disease		14. MANNER OF DEATH Natural		15. INTERVIEWED Yes		16. SIGNATURE OF DECEASED James H. Harris		17. SIGNATURE OF WITNESS John D. Smith		18. SIGNATURE OF PHYSICIAN Dr. J. K. Brown	
19. SIGNATURE OF REGISTRAR John D. Smith		20. SIGNATURE OF CLERK John D. Smith		21. SIGNATURE OF DECEASED James H. Harris		22. SIGNATURE OF WITNESS John D. Smith		23. SIGNATURE OF PHYSICIAN Dr. J. K. Brown		24. SIGNATURE OF REGISTRAR John D. Smith	

CHESTER BOARD

BUREAU V. 5

FEB 3 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

392

## CERTIFICATE OF DEATH

Reg. Dist. No.

00386

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklandville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College manor</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Shaw</u> Last <u>Shaw</u>		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 21, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>2</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Estate</u>	
11. BIRTHPLACE (State or foreign country) <u>County Cheshire England</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John Shaw</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Shatwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1/9</u> to <u>1/11/58</u> , that I last saw the deceased alive on <u>1/9</u> , 19 <u>58</u> , and that death occurred at <u>10:19</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Fritz</u>		ADDRESS (Street, city or town, state) <u>2 W. University Pky., Balto., Md.</u> DATE SIGNED <u>1/11/58</u>	
PHYSICIAN'S NAME (Type) <u>William F. Fritz</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 11, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lutherville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Dunn Sons</u>		ADDRESS <u>Towson, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. DATE OF DEATH</p>	
<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESSES</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF BURIAL OFFICIAL</p>		<p>18. SIGNATURE OF FUNERAL HOME</p>	
<p>19. SIGNATURE OF CHURCH OFFICIAL</p>		<p>20. SIGNATURE OF CEMETERY OFFICIAL</p>	
<p>21. SIGNATURE OF HEALTH DEPARTMENT</p>		<p>22. SIGNATURE OF COUNTY CLERK</p>	
<p>23. SIGNATURE OF STATE DEPARTMENT OF HEALTH</p>		<p>24. SIGNATURE OF U.S. DEPARTMENT OF HEALTH</p>	

BUREAU V. S.

JAN 18 1953

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00387

Reg. Dist. No.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1819 Guilford AVE</u>	
3. NAME OF DECEASED (Type or print) <u>CARRIE SHELTON</u>		4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-34</u>
9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>MILES WILKINS</u>		14. MOTHER'S MAIDEN NAME <u>CHERRY BULLOCK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Cherry Wilkins</u>		Address <u>1819 Guilford AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Hemorrhage into Left Chest &amp; Abdomen</u> 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gunsight wounds of Chest &amp; Abdomen</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William Upchurch</u>		DATE SIGNED <u>1-12-58</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>	22d. LOCATION (City, town, or county) (State) <u>A.A. COUNTY, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph G. Locks, Jr.</u>		24a. REC'D BY REGISTRAR <u>15 58</u> DATE <u>JAN 15 58</u>	
ADDRESS <u>1204 N. CENTRAL AVE</u>		24b. REGISTRAR'S SIGNATURE <u>Albee</u>	

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JAN 16 1958

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JAN 16 1958  
BUREAU V. S.

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. RESIDENCE	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF CORONER	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF JURY		21. SIGNATURE OF CORONER	
22. SIGNATURE OF MEDICAL EXAMINER		23. SIGNATURE OF JURY		24. SIGNATURE OF CORONER	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF JURY		27. SIGNATURE OF CORONER	
28. SIGNATURE OF MEDICAL EXAMINER		29. SIGNATURE OF JURY		30. SIGNATURE OF CORONER	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF JURY		33. SIGNATURE OF CORONER	
34. SIGNATURE OF MEDICAL EXAMINER		35. SIGNATURE OF JURY		36. SIGNATURE OF CORONER	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF JURY		39. SIGNATURE OF CORONER	
40. SIGNATURE OF MEDICAL EXAMINER		41. SIGNATURE OF JURY		42. SIGNATURE OF CORONER	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF JURY		45. SIGNATURE OF CORONER	
46. SIGNATURE OF MEDICAL EXAMINER		47. SIGNATURE OF JURY		48. SIGNATURE OF CORONER	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF JURY		51. SIGNATURE OF CORONER	
52. SIGNATURE OF MEDICAL EXAMINER		53. SIGNATURE OF JURY		54. SIGNATURE OF CORONER	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF JURY		57. SIGNATURE OF CORONER	
58. SIGNATURE OF MEDICAL EXAMINER		59. SIGNATURE OF JURY		60. SIGNATURE OF CORONER	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF JURY		63. SIGNATURE OF CORONER	
64. SIGNATURE OF MEDICAL EXAMINER		65. SIGNATURE OF JURY		66. SIGNATURE OF CORONER	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF JURY		69. SIGNATURE OF CORONER	
70. SIGNATURE OF MEDICAL EXAMINER		71. SIGNATURE OF JURY		72. SIGNATURE OF CORONER	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF JURY		75. SIGNATURE OF CORONER	
76. SIGNATURE OF MEDICAL EXAMINER		77. SIGNATURE OF JURY		78. SIGNATURE OF CORONER	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF JURY		81. SIGNATURE OF CORONER	
82. SIGNATURE OF MEDICAL EXAMINER		83. SIGNATURE OF JURY		84. SIGNATURE OF CORONER	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF JURY		87. SIGNATURE OF CORONER	
88. SIGNATURE OF MEDICAL EXAMINER		89. SIGNATURE OF JURY		90. SIGNATURE OF CORONER	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF JURY		93. SIGNATURE OF CORONER	
94. SIGNATURE OF MEDICAL EXAMINER		95. SIGNATURE OF JURY		96. SIGNATURE OF CORONER	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF JURY		99. SIGNATURE OF CORONER	
100. SIGNATURE OF MEDICAL EXAMINER		101. SIGNATURE OF JURY		102. SIGNATURE OF CORONER	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>58 S. Dundalk Ave.</b>		d. STREET ADDRESS <b>58 S. Dundalk Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>JOHANNA SHORNEY</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>23,</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1886</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Czechoſlovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>? Slezak</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Joseph Hollar 6800 Dunhill Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cornary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C.-V.-Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M B Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M B Davis M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 27, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, lawn, or county) (State) <b>Colgate, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 27 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. F. Leach</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00389

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> Sparrows Point MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>2717 W. North Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Earl L. SIMMONS</u>		4. DATE OF DEATH Month Day Year <u>January 20 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30, 1930</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Loco Crane Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Charlotte, S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Simmons</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Bolher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-26-1371</u>	
17. INFORMANT <u>Evelyn Simmons</u>		Address <u>2717 W. North Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decapitation</u> 912.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran over by Locomotive Crane</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:40 p.m. 1-20 1958</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Both Steel Co.</u>		20f. (City or town) (County) (State) <u>Sparrows Pt Baltimore Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 24, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>802 Madison Avenue</u>	
24a. REC'D BY REGISTRAR <u>JAN 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>John Smith</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 23 1933

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 00390

1. PLACE OF DEATH o. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DAYTON 13x-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>/</b>	
3. NAME OF DECEASED (Type or print) First <b>BRADLEY</b> Middle <b>SIMPSON</b> Last <b>SIMPSON</b>		4. DATE OF DEATH Month <b>1</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FISHERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>HAMILTON SIMPSON</b>		14. MOTHER'S MAIDEN NAME <b>LAURA JOHNSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UR/RE/MVA/ Pulmonary Tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PR/WH/ON/AR/11/TW/BR/RI/CL/LL/BB/VI/ Uremia</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4/25, 1957</b> , to <b>6/17, 1958</b> , that I last saw the deceased alive on <b>1/17, 1958</b> , and that death occurred at <b>11/55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b>		PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b> <b>Superintendent</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1-20-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PROVIDENCE</b>	22d. LOCATION (City, town, or county) (State) <b>GLENELG, MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. HIGINBOTHAM, ELLICOTT CITY MD</b>		24a. REC'D BY REGISTRAR <b>JAN 22 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Quinn</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>	
3. AGE <b>65</b>		4. DATE OF BIRTH <b>1873</b>	
5. PLACE OF BIRTH <b>NEW YORK</b>		6. OCCUPATION <b>LABORER</b>	
7. MARITAL STATUS <b>MARRIED</b>		8. DATE OF DEATH <b>JAN 22 1938</b>	
9. PLACE OF DEATH <b>HOME</b>		10. CAUSE OF DEATH <b>HEART DISEASE</b>	
11. MEDICAL HISTORY <b>None</b>		12. SIGNATURE OF PHYSICIAN <b>[Signature]</b>	
13. SIGNATURE OF WITNESSES <b>[Signature]</b>		14. SIGNATURE OF REGISTRAR <b>[Signature]</b>	
15. DATE OF REGISTRATION <b>JAN 22 1938</b>		16. OFFICE OF REGISTRATION <b>BALTIMORE</b>	

**RECEIVED**  
**BUREAU V. S.**  
**JAN 22 1938**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN TB <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>901 W. 40th Street</u>			
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>G</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/4/89</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Antique Dealer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Antiques</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Michael Smith</u>			
14. MOTHER'S MAIDEN NAME <u>Edith R. Brown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u> <u>None</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY CONGESTION AND EDEMA</u> <u>442X</u> <u>XNXX</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>NEPHROSCLEROSIS</u> DUE TO (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR/</u> DISEASE				INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>UNKNOWN</u> <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that <u>VA</u> attended the deceased from <u>December 30</u> , 19 <u>57</u> , to <u>January 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 12</u> , 19 <u>58</u> , and that death occurred at <u>4:10 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH Fort Howard, Maryland</u> DATE SIGNED <u>1/13/58</u> ACTUAL SIGNATURE <u>Chien Wei Lan</u> M.D. <u>VAH Fort Howard, Maryland</u> PHYSICIAN'S NAME (Type) <u>CHIEN WEI LAN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Saunders Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc.</u>				ADDRESS <u>6009 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 20 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alb. Beach</u>							

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 396 CERTIFICATE OF DEATH

00392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>3yr2mth6dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				5. SEX <b>female</b>			
6. COLOR OR RACE <b>white</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1958</b>				9. AGE (In years last birthday) <b>85?</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan. 15, 1958</b> , to <b>Jan. 16, 1958</b> , that I last saw the deceased alive on <b>Jan. 16, 1958</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				M.D. <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>1-16-58</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1/16/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Phila., Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS</b>				ADDRESS <b>Balto. 17, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 17 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Deborah</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

JAN 20 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 397 CERTIFICATE OF DEATH

00393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
				d. STREET ADDRESS <b>3535 Virginia Ave.</b>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WEBER</b> Middle <b>H.</b> Last <b>SNYDER</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>20,</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 9, 1884</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist (rtd)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>George Snyder</b>				14. MOTHER'S MAIDEN NAME <b>Corine -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address <b>Mrs. Nettie L. Snyder - 3535 Virginia Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Cerebral Vascular Accidents</b> <b>331X</b> DUE TO <b>Multiple old &amp; New</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>② Congestive Heart Failure</b> DUE TO (c) <b>Chronic &amp; Acute</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>1/19/58</b> (County) (State)			
21. I certify that I attended the deceased from <b>1/19/58</b> 19 to <b>1/20/58</b> 19, that I last saw the deceased alive on <b>1/19/58</b> 19, and that death occurred at <b>12:45 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 28md</b> DATE SIGNED <b>1/20/58</b>							
ACTUAL SIGNATURE <b>W. E. McGloth</b> M.D.				DATE SIGNED <b>1/20/58</b>			
PHYSICIAN'S NAME (Type) <b>W. E. McGloth</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/23/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Krider's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner &amp; Sons - Baltimore</b>				24a. REC'D BY REGISTRAR <b>Wm. J. Dickner</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. J. Dickner</b>	
				DATE <b>JAN 22 '58</b>			

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

398

## CERTIFICATE OF DEATH

00394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3624 Hilmar Rd.</b>		d. STREET ADDRESS <b>3624 Hilmar Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH LAWRENCE</b> Middle <b>SPILKER</b> Last		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 24, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired house painter -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mr. Lawrence S. Spilker - 3624 Hilmar Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>345X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO <b>Multiple Sclerosis</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>one week</b> <b>4 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 15, 1957</b> , to <b>JANUARY 24, 1958</b> , that I last saw the deceased alive on <b>January 22, 1958</b> , and that death occurred at <b>7:20 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edwin J. Purpurt</b>		ADDRESS (Street, city or town, state) <b>8204 L. BERTY RD, BALTO, MD</b>	
DATE SIGNED <b>1/24/58</b>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/27/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner &amp; Sons - Balto 17th</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE <b>Overman</b>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

JAN 28 1958

RECEIVED

399

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Nd.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Villa Nova</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Villa Nova</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7317 Rockridge Rd.</u>				e. STREET ADDRESS <u>7317 Rockridge Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>E.</u> Last <u>SPITZNAS</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>10,</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1892</u>	9. AGE (In years last birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director of Instruction</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>State Dept. Edu.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>  </u>				13. FATHER'S NAME <u>Albert Spitznas</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Goldsworthy</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>World War I</u>			
16. SOCIAL SECURITY NO. <u>I</u>				17. INFORMANT <u>Mrs. Elizabeth Spitznas - 7317 Rockridge Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease.</u> DUE TO (c) <u>arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 m. 12.</u> <u>2 yrs.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>56</u> , to <u>Jan 10, 1958</u> , that I last saw the deceased alive on <u>Jan. 9, 1958</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>Jonas H. Cohen</u>				M.D. <u>  </u>			
PHYSICIAN'S NAME (Type) <u>JONAS H. COHEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Allegany Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner &amp; Sons - Baltor, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 14 1953

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

400

## CERTIFICATE OF DEATH

Reg. Dist. No. 00396

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b> c. LENGTH OF STAY IN 1b <b>8 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport, Maryland</b> d. STREET ADDRESS <b>Route # 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Linda</b> Middle <b>Darlene</b> Last <b>Sprecher</b>		4. DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/6/49</b>
9. AGE (In years last birthday) <b>8</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b> Hours <b>2</b> Min.	IF UNDER 24 HRS. Hours <b>2</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Clarence Leroy Sprecher</b>		14. MOTHER'S MAIDEN NAME <b>Gladys Snyder Long</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Rosewood Records</b> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Status Epilepticus</b> <b>353.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Moderate mental retardation (familial) with</b> DUE TO (c) <b>behavior disorder.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>since birth</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>7:10 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rosewood State Training School</b> DATE SIGNED <b>1/30/58</b>			
ACTUAL SIGNATURE <b>Harry G. Butler</b>		M.D. <b>Rosewood State Training School</b>	
PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/1/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul</b>	22d. LOCATION (City, town, or county) (State) <b>Clear Spring, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Al Hoffman</b> ADDRESS <b>Nagustan Md</b>		24a. REC'D BY REGISTRAR <b>FEB 3 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Q. L. Smith</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ALL INFORMATION  
OBTAINED FROM THIS  
OFFICE IS UNCLASSIFIED  
DATE 10-10-01 BY 60322 UCBAW

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is oriented horizontally but contains vertical text labels for various categories.

BUREAU V. 8

1958 3 18

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

401

## CERTIFICATE OF DEATH

00397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. STREET ADDRESS <b>2034 COUGH STREET</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES RAYMOND STALLINGS</b>				4. DATE OF DEATH Month Day Year <b>Jan 30 1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-20-1891</b>	
9. AGE (In years last birthday) yrs. <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES STALLINGS</b>				14. MOTHER'S MAIDEN NAME <b>MARY STALLINGS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>705-09-8039</b>			
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>TWO YEARS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>EMPHYSEMA</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1-25-1956</b> to <b>1-30-1958</b> , that I last saw the deceased alive on <b>1-29-1958</b> , and that death occurred at <b>2:50 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b>				DATE SIGNED <b>1-30-58</b>			
ACTUAL SIGNATURE <b>William Newcomer</b>				M.D. <b>Superintendent</b>			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Silly &amp; Zeeler Inc. 1901 Eastern Ave</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	

CERTIFICATE OF DEATH

FILE NO. 211

1. NAME OF DECEASED JOHN J. JONES		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH FEB 2 1958		6. PLACE OF DEATH Home	
7. TIME OF DEATH 10:00 AM		8. CAUSE OF DEATH Heart Disease	
9. MANNER OF DEATH Natural		10. SIGNATURE OF PHYSICIAN J. J. JONES	
11. SIGNATURE OF REGISTRAR J. J. JONES		12. SIGNATURE OF WITNESSES J. J. JONES	
13. SIGNATURE OF DECEASED J. J. JONES		14. SIGNATURE OF NEXT OF KIN J. J. JONES	
15. SIGNATURE OF BURIAL OFFICIAL J. J. JONES		16. SIGNATURE OF CHURCH OFFICIAL J. J. JONES	
17. SIGNATURE OF FUNERAL HOME J. J. JONES		18. SIGNATURE OF CEMETERY J. J. JONES	
19. SIGNATURE OF MORTUARY J. J. JONES		20. SIGNATURE OF CEMETERY J. J. JONES	
21. SIGNATURE OF MORTUARY J. J. JONES		22. SIGNATURE OF CEMETERY J. J. JONES	
23. SIGNATURE OF MORTUARY J. J. JONES		24. SIGNATURE OF CEMETERY J. J. JONES	
25. SIGNATURE OF MORTUARY J. J. JONES		26. SIGNATURE OF CEMETERY J. J. JONES	
27. SIGNATURE OF MORTUARY J. J. JONES		28. SIGNATURE OF CEMETERY J. J. JONES	
29. SIGNATURE OF MORTUARY J. J. JONES		30. SIGNATURE OF CEMETERY J. J. JONES	
31. SIGNATURE OF MORTUARY J. J. JONES		32. SIGNATURE OF CEMETERY J. J. JONES	
33. SIGNATURE OF MORTUARY J. J. JONES		34. SIGNATURE OF CEMETERY J. J. JONES	
35. SIGNATURE OF MORTUARY J. J. JONES		36. SIGNATURE OF CEMETERY J. J. JONES	
37. SIGNATURE OF MORTUARY J. J. JONES		38. SIGNATURE OF CEMETERY J. J. JONES	
39. SIGNATURE OF MORTUARY J. J. JONES		40. SIGNATURE OF CEMETERY J. J. JONES	
41. SIGNATURE OF MORTUARY J. J. JONES		42. SIGNATURE OF CEMETERY J. J. JONES	
43. SIGNATURE OF MORTUARY J. J. JONES		44. SIGNATURE OF CEMETERY J. J. JONES	
45. SIGNATURE OF MORTUARY J. J. JONES		46. SIGNATURE OF CEMETERY J. J. JONES	
47. SIGNATURE OF MORTUARY J. J. JONES		48. SIGNATURE OF CEMETERY J. J. JONES	
49. SIGNATURE OF MORTUARY J. J. JONES		50. SIGNATURE OF CEMETERY J. J. JONES	
51. SIGNATURE OF MORTUARY J. J. JONES		52. SIGNATURE OF CEMETERY J. J. JONES	
53. SIGNATURE OF MORTUARY J. J. JONES		54. SIGNATURE OF CEMETERY J. J. JONES	
55. SIGNATURE OF MORTUARY J. J. JONES		56. SIGNATURE OF CEMETERY J. J. JONES	
57. SIGNATURE OF MORTUARY J. J. JONES		58. SIGNATURE OF CEMETERY J. J. JONES	
59. SIGNATURE OF MORTUARY J. J. JONES		60. SIGNATURE OF CEMETERY J. J. JONES	
61. SIGNATURE OF MORTUARY J. J. JONES		62. SIGNATURE OF CEMETERY J. J. JONES	
63. SIGNATURE OF MORTUARY J. J. JONES		64. SIGNATURE OF CEMETERY J. J. JONES	
65. SIGNATURE OF MORTUARY J. J. JONES		66. SIGNATURE OF CEMETERY J. J. JONES	
67. SIGNATURE OF MORTUARY J. J. JONES		68. SIGNATURE OF CEMETERY J. J. JONES	
69. SIGNATURE OF MORTUARY J. J. JONES		70. SIGNATURE OF CEMETERY J. J. JONES	
71. SIGNATURE OF MORTUARY J. J. JONES		72. SIGNATURE OF CEMETERY J. J. JONES	
73. SIGNATURE OF MORTUARY J. J. JONES		74. SIGNATURE OF CEMETERY J. J. JONES	
75. SIGNATURE OF MORTUARY J. J. JONES		76. SIGNATURE OF CEMETERY J. J. JONES	
77. SIGNATURE OF MORTUARY J. J. JONES		78. SIGNATURE OF CEMETERY J. J. JONES	
79. SIGNATURE OF MORTUARY J. J. JONES		80. SIGNATURE OF CEMETERY J. J. JONES	
81. SIGNATURE OF MORTUARY J. J. JONES		82. SIGNATURE OF CEMETERY J. J. JONES	
83. SIGNATURE OF MORTUARY J. J. JONES		84. SIGNATURE OF CEMETERY J. J. JONES	
85. SIGNATURE OF MORTUARY J. J. JONES		86. SIGNATURE OF CEMETERY J. J. JONES	
87. SIGNATURE OF MORTUARY J. J. JONES		88. SIGNATURE OF CEMETERY J. J. JONES	
89. SIGNATURE OF MORTUARY J. J. JONES		90. SIGNATURE OF CEMETERY J. J. JONES	
91. SIGNATURE OF MORTUARY J. J. JONES		92. SIGNATURE OF CEMETERY J. J. JONES	
93. SIGNATURE OF MORTUARY J. J. JONES		94. SIGNATURE OF CEMETERY J. J. JONES	
95. SIGNATURE OF MORTUARY J. J. JONES		96. SIGNATURE OF CEMETERY J. J. JONES	
97. SIGNATURE OF MORTUARY J. J. JONES		98. SIGNATURE OF CEMETERY J. J. JONES	
99. SIGNATURE OF MORTUARY J. J. JONES		100. SIGNATURE OF CEMETERY J. J. JONES	

RECEIVED  
FEB 3 1958  
BUREAU V. A.

402 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2903 Roborn Avenue</u>		d. STREET ADDRESS <u>2903 Roborn Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Daniel Louis Stone</u>		4. DATE OF DEATH Month Day Year <u>January 6th 19 58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1894</u>
9. AGE (In years last birthday) <u>63 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk, Baltimore City</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>217-07-9258</u>	
17. INFORMANT <u>Mrs. Hazel Porter Stone</u>		Address <u>2903 Roborn</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> (c) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>57</u> to <u>Jan 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Fusting</u> M.D.		ADDRESS (Street, city or town, state) <u>4230 Loch Raven Blve.</u>	
PHYSICIAN'S NAME (Type) <u>William H. Fusting</u>		DATE SIGNED <u>1/7/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u>
22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>JAN 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

RECEIVED

1958 8 JAN

BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00399

403

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Augsburg Lutheran Home</b>				d. STREET ADDRESS <b>Severna Park - Round Bay 02x-2</b>			
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>M.</b> Last <b>STOWE</b>				4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 20, 1876</b>		9. AGE (In years last birthday) <b>81 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>81</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George Reiblich</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Schmidt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Augsburg Lutheran Home Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) - Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(1) - Hypertensive Heart Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 wks. 10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>March 14, 1954</b> to <b>Jan 14, 1958</b> ; that I last saw the deceased alive on <b>Jan 14, 1958</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Earl L. Chambers</b>				ADDRESS (Street, city or town, state) <b>4108 Liberty Hts. Balt. Md.</b> DATE SIGNED <b>1/15/58</b>			
PHYSICIAN'S NAME (Type) <b>Earl L. Chambers, M.D.</b>				4108 Liberty Heights Ave.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/17/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Randallstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Couch</b>	

## JALYND AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

JAN 20 1953

RECEIVED



404

## CERTIFICATE OF DEATH

00400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6107 Windsor Mill Road</b>				d. STREET ADDRESS <b>6107 Windsor Mill Road</b>			
3. NAME OF DECEASED (Type or print) <b>Frances Isabella Strahler</b>				4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1888</b>		9. AGE (In years lost birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William Airey</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Joseph Strahler, Sr. 6107 Windsor Mill Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>One year</b> <b>9 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 10, 1957</b> , to <b>January 22, 1958</b> , that I last saw the deceased alive on <b>January 17, 1958</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edwin L. Pierpont</b>				ADDRESS (Street, city or town, state) <b>8204 Liberty Road, Baltimore 7, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Edwin L. Pierpont, M.D.</b>				DATE SIGNED <b>1/22/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/28/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL HOME'S SIGNATURE <b>Ellsworth Armacost</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Ellsworth Armacost</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00401

405

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Stevenson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hillside Rd</u>				d. STREET ADDRESS <u>Hillside Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARTHA</u> First <u>Goldsborough</u> Middle <u>Stump</u> Last				4. DATE OF DEATH <u>Jan</u> Month <u>23</u> Day <u>1958</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 24 1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co., Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Richard B. Post</u>				14. MOTHER'S MAIDEN NAME <u>Ella</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Norman Stump</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis +</u> DUE TO (c) <u>hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs 6 mos</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/12</u> , 19 <u>47</u> , to <u>Jan 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>58</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Palmer F. Williams</u> M.D.				ADDRESS (Street, city or town, state) <u>Pikesville B. Md.</u>		DATE SIGNED <u>1/24/58</u>	
PHYSICIAN'S NAME (Type) <u>PALMER F. C. WILLIAMS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 25 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Thomas</u>		22d. LOCATION (City, town, or county) (State) <u>Garrison Forest Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Jenkins</u> ADDRESS <u>4905 York Rd</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carl Smith</u>	

IAN 27 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>4110 Essex Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Anne</u> Middle <u>E</u> Last <u>Sussman</u>		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Nathan Meth</u>		14. MOTHER'S MAIDEN NAME <u>Hannah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records</u>		Address <u>SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) _____ (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several years</u> <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 2</u> , 19 <u>57</u> , to <u>1/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/10</u> , 19 <u>58</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radawski</u> M.D.		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>	
DATE SIGNED <u>1/10/1958</u>			
PHYSICIAN'S NAME (Type) <u>BRUNO RADAWSKI</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-12-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Herrington Run</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u>		ADDRESS <u>2100 Eutan Pl</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al Lewis</u>	





CERTIFICATE OF DEATH

00403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3110 Du Bois Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mrs. Elizabeth C. Sweglar</i>				4. DATE OF DEATH <i>January 10th 1958</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 15, 1875</i>	9. AGE (In years last birthday) <i>82</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Miss Genevieve T. Sweglar, same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chr. myocardial degeneration</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i> <i>10 yrs +</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260x Diabetes mellitus - duration 20 yrs.</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. <i>p. m.</i> <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <i>1939</i> to <i>Jan. 10, 1958</i> , that I last saw the deceased alive on <i>Jan. 9, 1958</i> , and that death occurred at <i>12:15 A.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>2810 Taylor Ave.</i> DATE SIGNED <i>Q. M. Bacon</i>							
ACTUAL SIGNATURE <i>Q. M. Bacon</i>		M.D. <i>2810 Taylor Ave.</i>					
PHYSICIAN'S NAME (Type) <i>A. M. BACON</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/13/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road.</i>				24a. REC'D BY REGISTRAR <i>MAN 1 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Q. M. Bacon</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 13 1958

RECEIVED

## 408 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>1556.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Tr. School</u>		d. STREET ADDRESS <u>2314 Michigan Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Keturah</u> Last <u>Talley</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-55</u>
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Patient</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Grayson E. Talley</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Virginia Wm.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>                    </u>		Address <u>                    </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Double hemiparesis &amp; bilateral</u> DUE TO (c) <u>athetosis &amp; extensive cerebral damage</u> Birth			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(Bone ganglion) secondary to neo-natal jaundice.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 1, 1957</u> to <u>Jan. 4, 1958</u> , that I last saw the deceased alive on <u>Jan. 4, 1958</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry G. Butler</u>		DATE SIGNED <u>7 Jan '58</u>	
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>		ADDRESS (Street, city or town, state) <u>Owings Mills, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>                    </u>	22b. DATE THEREOF <u>1/8.58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>W. of Md. State School</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.H. Newell - Pikesville</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 10 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>                    </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 13 1953

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

00405

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>4yr6mths10dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>19 58</b>				5. SEX <b>female</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>Feb. 6, 1882</b>				9. AGE (In years last birthday) <b>75</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>saleslady</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Tefill</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Art-eriosclerotic cardiovascular disease</b> DUE TO <b>G eneralized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec. 24</b> , 19 <b>57</b> , to <b>Jan. 20 1958</b> , 19____, that I last saw the deceased alive on <b>1-20-1958</b> , 19 <b>58</b> , and that death occurred at <b>3:35 A. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachsler</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>1-20-58</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>				<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 21 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Road Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nippel Bros 7110 Belair Rd</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JAN 22 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Outreach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 22 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG224 1-23-58 et

410

## CERTIFICATE OF DEATH

Reg. Dist. No.

00406

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice-Balto. Md.</b>				d. STREET ADDRESS <b>Eudowood Sanatorium-Towson, Md.</b>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Duplessis</b> Last <b>Tarr</b>				4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/1/1876</b>	9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse-Pharmacist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Nurse</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Wesley Tarr</b>				14. MOTHER'S MAIDEN NAME <b>Emma Dyer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-30-6352</b>		17. INFORMANT <b>George A. Herbert</b> Address <b>5300 Belleville Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Caecum</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>With Generalized Metastasis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>October 1, 1955</b> to <b>January 17, 1958</b> , that I last saw the deceased alive on <b>January 17, 1958</b> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.				ADDRESS (Street, city or town, state) <b>7501 York Rd.</b>			
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D. Towson, Md.</b>				DATE SIGNED <b>1/17/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-21-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>4600 Liberty Heights</b>				24a. REC'D BY REGISTRAR <b>Jan 20 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Ellsworth Armacost</b>	

RECEIVED

JAN 20 1953

BUREAU V. S.

*[Faint, illegible text, possibly a signature or address]*

*[Faint, illegible text]*

*[Faint, illegible text]*

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*[Faint, illegible text]*

*[Faint, illegible text]*

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 411 CERTIFICATE OF DEATH

00407

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>51 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>867 W. Fayette Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>R</b> Last <b>TASKER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/25/90</b>	
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Tasker</b>		14. MOTHER'S MAIDEN NAME <b>Rachel (Maiden name unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>218-10-3150</b>		17. INFORMANT Address <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>BASILAR ARTERY THROMBOSIS</b> DUE TO <b>ARTERIOSCLEROSIS, GENERALIZED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that VA attended the deceased from <b>November 20</b> , 19 <b>57</b> , to <b>January 10</b> , 19 <b>58</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Donald D. Mark</b> M.D. <b>VAH Fort Howard, Md.</b> <b>1/12/58</b> PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-15-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Deborah</b>	

VS A15 (4)  
15M 9/55

CHARLES R. LAW MORTUARY, 802-04 Madison Ave, Balto., Md

JAN 14 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 412 CERTIFICATE OF DEATH

Reg. Dist. No. 00408

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hidgeway Manor Conv. Home</b>				e. STREET ADDRESS <b>53 Garden Ridge Rd.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ADELA</b> Middle <b>H.</b> Last <b>TATE</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>9.</b> Year <b>1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1895</b>	
9. AGE (In years last birthday) <b>62 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Russell</b>				14. MOTHER'S MAIDEN NAME <b>Julia Mokey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>215-03-5116</b>		17. INFORMANT <b>Mr. Marion C. Roe, Jr.</b> Address <b>53 Garden Ridge Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Syphilitic Coroner Vascular Disease</b> <b>023x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Tertiary Syphilis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1946</b> , to <b>January 9, 1958</b> , that I last saw the deceased alive on <b>January 9, 1958</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2320 Euteria Place Balto Md</b> DATE SIGNED <b>1/10/58</b>							
ACTUAL SIGNATURE <b>Daniel J. Schwartz</b>		PHYSICIAN'S NAME (Type) <b>DANIEL J. SCHWARTZ, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekner &amp; Sons - Balto Md</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. Tiekner</b>	



BUREAU V. S.

JAN 14 1958

RECEIVED



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00409

413

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b <b>2 yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Essex</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) <b>945 Lance Ave</b>	
d. STREET ADDRESS <b>945 Lance Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Cobb</b> Last <b>Taylor</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>23</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 24 1884</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Household</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James A Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Norris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>First World</b>		16. SOCIAL SECURITY NO. <b>212-16-0071</b>	
17. INFORMANT <b>Joseph E Taylor (Son)</b>		Address <b>945 Lance Ave Balto 21 Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>neoplasm of bowel</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized, paraplegia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3.0 hrs.</b> <b>Several '70's</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/21</b> , 19 <b>58</b> , to <b>1/23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1/22</b> , 19 <b>58</b> , and that death occurred at <b>7:00</b> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Platt, M.D.</b>		ADDRESS (Street, city or town, state) <b>434 Eastern Ave</b>	
PHYSICIAN'S NAME (Type) <b>J. Platt, M.D.</b>		DATE SIGNED <b>1/24/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>January 27 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Morland Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Melville Jenkins</b>		ADDRESS <b>2713 Park Ave Balto md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

2. *Myiobella* *fulva* 2113 (Kearney)

BUREAU V. S.

JAN 27 1953

RECEIVED

414

## CERTIFICATE OF DEATH

Reg. Dist. No.

004110

1. PLACE OF DEATH a. COUNTY <u>Rosewood State Training School</u> <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. LENGTH OF STAY IN 1b <u>1 mo, 16 das.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>Apt. 8A 131 Asquith Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>Terry</u> Last <u>Terry</u>				4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/13/57</u>	
9. AGE (In years last birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				<u>Maryland</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Shirley Terry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Rosewood Records</u>		17. INFORMANT Address <u>Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mongoloid Idiocy</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>1:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>BALTO. Md.</u> DATE SIGNED <u>1/17/58</u>							
ACTUAL SIGNATURE <u>Rev. S. J. [illegible]</u> M.D.							
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. CALvary</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.O. Wilson</u>				ADDRESS <u>1000 Brantely Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>1/17/58</u>	
24b. REGISTRAR'S SIGNATURE <u>[illegible]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

JAN 21 1953

RECEIVED

415

## CERTIFICATE OF DEATH

00411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN 1b <u>5 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> d. STREET ADDRESS <u>826 Glenwood Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Brian</u> Middle <u>Stanley</u> Last <u>Thielman</u>				4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/24/55</u>	
9. AGE (In years last birthday) <u>2 yrs.</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Andrew Thielman</u>				14. MOTHER'S MAIDEN NAME <u>Annette M. Dillon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> <u>355x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cachexia - Cerebral Palsy &amp; Mental Deficiency</u> DUE TO (c) <u>Vascular atrophy of brain, bilateral subdural hygroma</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:50pm</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Rich. Gindenberg</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Rich. Gindenberg</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Lickner</u> ADDRESS <u>Sas N. Park</u>				24a. REC'D BY REGISTRAR <u>W. J. Lickner</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Lickner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

00412

Reg. Dist. No.

416

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN lb <b>57 Days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>C. THOMAS, JR.</b> Last			4. DATE OF DEATH Month <b>January</b> Day <b>30</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1901</b>		9. AGE (In years last birthday) yrs. <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Groceries</b>		11. BIRTHPLACE (State or foreign country) <b>Matthews Co., Virginia</b>	
13. FATHER'S NAME <b>Charles C. Thomas</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Clin. Rec., Vet. Admin. Hospital, Ft. Howard, Md.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF BLADDER WITH METASTASES</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that <b>I</b> attended the deceased from <b>December 4, 1957</b> , to <b>January 30, 1958</b> , and that death occurred at <b>9:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA</b> ACTUAL SIGNATURE <b>Irving Freeman</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>1/30/58</b> PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1-31-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Matthews County, Virginia</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co., Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 3 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Reed</b>		24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

FEB 3 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

417

CERTIFICATE OF DEATH

00413

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Md.</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u> 18X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Theodore Thompson</u>		4. DATE OF DEATH Month Day Year <u>1 / 1 / 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Orsterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert R. Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Susanna Joy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE BRONCHUS</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHO-PNEUMONIA (B) CORONARY ARTERIOSCLEROSIS</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>57</u> , to <u>1/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/1</u> , 19 <u>58</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street; city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William Newcomer</u>		M.D. <u>Mt. Wilson, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>William Newcomer, M. D., Superintendent</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		22d. LOCATION (City, town, or county) (State) <u>Leonardtown, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hittingly</u>		ADDRESS <u>Leonardtown, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 6 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hittingly</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

See Title 10

<p>1. NAME OF DECEASED                  [Faint text, possibly "John Doe"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>	
<p>3. AGE                  [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH                  [Faint text, possibly "Jan 1, 1910"]</p>	
<p>5. PLACE OF BIRTH                  [Faint text, possibly "Baltimore, Md"]</p>		<p>6. OCCUPATION                  [Faint text, possibly "Teacher"]</p>	
<p>7. CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>		<p>8. PLACE OF DEATH                  [Faint text, possibly "Home"]</p>	
<p>9. DATE OF DEATH                  [Faint text, possibly "Jan 5, 1958"]</p>		<p>10. TIME OF DEATH                  [Faint text, possibly "10:00 AM"]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [Faint signature]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Faint signature]</p>	

BUREAU V. S.

JAN 6 1958

RECEIVED

## 418 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westowne</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westowne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>205 Westshire Road</u>		d. STREET ADDRESS <u>205 Westshire Rd -</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN-LESLIE TIMMONS</u>		4. DATE OF DEATH <u>Jan 16 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Boiler Maker</u>		<u>B &amp; O R. R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joel L. Timmons</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Brittingham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>✓</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-05-4054</u> INFORMANT <u>Dora Timmons</u> Address <u>205 Westshire Rd 29</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Pulmonary Edema</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1957</u> to <u>Jan 16 1958</u> , that I last saw the deceased alive on <u>Jan 14 1958</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. C. MacLaughlin</u>		ADDRESS (Street, city or town, state) <u>4508 Edmondson Village</u> DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>D. C. MacLaughlin, M.D.</u>		<u>4508 Edmondson Village, Balto. 29, Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 20 1958</u>	<u>Woodlawn</u>	<u>Balto Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Veyfel</u> ADDRESS <u>5311 Edmondson Ave</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>
		DATE <u>JAN 20 58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED: *JOHN J. SMITH*

2. SEX: *MALE*

3. AGE: *45*

4. PLACE OF BIRTH: *NEW YORK*

5. DATE OF BIRTH: *1910*

6. PLACE OF DEATH: *BALTIMORE*

7. DATE OF DEATH: *1958*

8. TIME OF DEATH: *10:00 AM*

9. CAUSE OF DEATH: *HEART DISEASE*

10. PLACE OF INTERMENT: *GREENWOOD CEMETERY*

11. NAME OF MINISTER: *JOHN J. SMITH*

12. NAME OF CLERGYMAN: *JOHN J. SMITH*

13. NAME OF FUNERAL HOME: *JOHN J. SMITH*

14. NAME OF BURIAL PLACE: *JOHN J. SMITH*

15. NAME OF CEMETERY: *JOHN J. SMITH*

16. NAME OF FUNERAL HOME: *JOHN J. SMITH*

17. NAME OF BURIAL PLACE: *JOHN J. SMITH*

18. NAME OF CEMETERY: *JOHN J. SMITH*

19. NAME OF FUNERAL HOME: *JOHN J. SMITH*

20. NAME OF BURIAL PLACE: *JOHN J. SMITH*

21. NAME OF CEMETERY: *JOHN J. SMITH*

22. NAME OF FUNERAL HOME: *JOHN J. SMITH*

23. NAME OF BURIAL PLACE: *JOHN J. SMITH*

24. NAME OF CEMETERY: *JOHN J. SMITH*

25. NAME OF FUNERAL HOME: *JOHN J. SMITH*

26. NAME OF BURIAL PLACE: *JOHN J. SMITH*

27. NAME OF CEMETERY: *JOHN J. SMITH*

28. NAME OF FUNERAL HOME: *JOHN J. SMITH*

29. NAME OF BURIAL PLACE: *JOHN J. SMITH*

30. NAME OF CEMETERY: *JOHN J. SMITH*

BUREAU V. S.

JAN 20 1958

RECEIVED





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00415

## 419 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home in the Pines 17 Fustiny Ave</u>		d. STREET ADDRESS <u>2505 Liberty Heights Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>TOCKER</u> Last		4. DATE OF DEATH Month <u>Jan</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>?</u>		13. FATHER'S NAME <u>Gale Snyder</u>	
14. MOTHER'S MAIDEN NAME <u>Sera?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Lee Eisenstein</u> Address <u>2505 Liberty Hts Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>gangrene</u> (c) <u>Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>4 wk.</u> <u>several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General arterio sclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1, 1957</u> to <u>Jan 25, 1958</u> , that I last saw the deceased alive on <u>Jan 24, 1958</u> , and that death occurred at <u>6:15 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Christian S. Mass</u> M.D.		ADDRESS (Street, City or town, state) <u>11 E. Chase</u> DATE SIGNED <u>1/25/58</u>	
PHYSICIAN'S NAME (Type) <u>CHRISTIAN S. MASS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Adath Jeshurun</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Ginnon</u> ADDRESS <u>1124-26 N. North Ave</u>		24a. REC'D BY REGISTRAR <u>JAN 27 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Chase</u>



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AT-HOME</b>		d. STREET ADDRESS <b>1521 BACK RIVER NK RD</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA Tschirschky</b>		4. DATE OF DEATH Month Day Year <b>JAN 18 1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-11-1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT-HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Boschold</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Elizabeth DORAK</b>		Address <b>(same)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO <b>20 yrs?</b> (c) <b>Senile Dementia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491x</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 16</b> , 19 <b>58</b> , to <b>Jan. 16</b> , 19 <b>58</b> , and that death occurred at <b>930</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry B. Smith</b>		M.D. <b>413 Eastern Avenue</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>HARRY B. SMITH</b>		<b>Baltimore 21, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>	<b>1-21-58</b>	<b>OAK-LAWN</b>	<b>BALTO MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly - Essex MD.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 22 '58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 22 1958

RECEIVED

421

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 Mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1630 Edmondson</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ione E.</u> Middle <u>Turlington</u> Last		4. DATE OF DEATH Month <u>January</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1885</u>
9. AGE (In years last birthday) yrs. <u>72</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Irvington, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Spencer George</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. George Mellor</u>		Address <u>1630 Edmondson Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio-Sclerotic Disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-10-</u> 19 <u>57</u> to <u>1-22-</u> 19 <u>58</u> , that I last saw the deceased alive on <u>1-22-58</u> 19 <u>  </u> , and that death occurred at <u>5A</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph G. Laukaitis</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>679 Washington Blvd - Baltimore 30</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Joseph G. Laukaitis</u>		<u>679 Washington Boulevard</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 24, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Home Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Irvington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmore &amp; Haynie Funeral Home, Kilmarnock, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Albert</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 5

JAN 23 1953

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G225 1-30-58 et

CERTIFICATE OF DEATH

00418

Reg. Dist. No.

422

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>52 CATONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SHADY NOOK</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY A.</b> Middle <b>TURNER</b> Last <b>TURNER</b>		4. DATE OF DEATH Jan. <b>JULY</b> 20 1958.	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 23/1876</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NOT EMPLOYD</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>LAPLATA MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WADE</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE YOUNGMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>XXXXX</b>	
17. INFORMANT <b>CATHERINE OZAZEWski</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis with Hypertension</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Oct 11/1957</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1/58</b> to <b>11/30</b> , 1958, that I last saw the deceased alive on <b>1/20</b> , 1958, and that death occurred at <b>12/10</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Samuel Pelleya M.D. 3726 Frederick Ave Baltimore 1/24/58.</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W Ozazewski</b>		24a. REC'D BY REGISTRAR <b>1930 Eastern Ave</b>	
24b. REGISTRAR'S SIGNATURE <b>Alberich</b>		DATE <b>JAN 23 '58</b>	

CERTIFICATE OF DEATH

The following

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARITAL STATUS		OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		TEMPERATURE		PULSE	
CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		INTERMEDIATE CAUSE		UNDERLYING CAUSE		PREEXISTING DISEASES		TREATMENT		POSTMORTEM EXAMINATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGYMAN		SIGNATURE OF OTHER	

BUREAU V. 4

JAN 23 1938

RECEIVED

423

## CERTIFICATE OF DEATH

Reg. Dist. No.

00419

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>1347 Upper Landing Rd</u>			
3. NAME OF DECEASED (Type or print) <u>LOUIS</u> First <u>UHL</u> Middle <u>UHL</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/18/08</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Louis Uhl</u>				14. MOTHER'S MAIDEN NAME <u>Marie Uhl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Marie Uhl wife</u> Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of liver</u> DUE TO (c) <u>Arterio-sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 year</u> <u>20 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> 19 <u>50</u> , to <u>Jan 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 11</u> , 19 <u>58</u> , and that death occurred at <u>10</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1010 North Point Rd</u> DATE SIGNED <u>11/15/58</u> ACTUAL SIGNATURE <u>Morris A. Jacobs</u> M.D. PHYSICIAN'S NAME (Type) <u>MORRIS A. JACOBS M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Schwartz's</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly - Essex Md.</u> ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	
				DATE <u>JAN 20 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 20 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Pt. Road</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>2503 North Point Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>George W. Williams</u> First <u>George</u> Middle <u>William</u> Last <u>Williams</u>				4. DATE OF DEATH <u>Jan 8</u> Month <u>Jan</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 23 1890</u> AGE (In years last birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Williams</u>				14. MOTHER'S MAIDEN NAME <u>Katie Philipp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u> 17. INFORMANT <u>Mrs Heigerson 417 E. Lafayette Ave</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular Arteriosclerotic Disease</u> DUE TO (c) <u>20 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>55</u> , to <u>Jan 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 2</u> , 19 <u>58</u> , and that death occurred at <u>11</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David Owen, Jr. D.</u> M.D. <u>914 D St. Bk Hs. 19, Md.</u>				DATE SIGNED <u>1/8/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 11 1958 Baltimore</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>E. North Ave Cst</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leo G. Hook 1704-03 W. Patterson Ph. Ave</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Jan 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Heigerson</u>	



BUREAU V. S.

JAN 13 1953

RECEIVED



425

CERTIFICATE OF DEATH

00421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 Oakdale Ave.</u>				d. STREET ADDRESS <u>110 Oakdale Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mae</u> Middle <u>Christine</u> Last <u>Utter</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>24</u> Year <u>19 58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1889</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church Rectory</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ferdinand Bruns</u>				14. MOTHER'S MAIDEN NAME <u>Johanna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>--</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mildred Francis</u> Address <u>110 Oakdale Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac dilatation</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic myocarditis Hypertension</u> DUE TO (c) <u>Hemiplegia right 3 yrs ago</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>54</u> , to <u>1-24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-20-58</u> 19 <u>58</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>477 Sallow Ave</u> DATE SIGNED <u>1-27-58</u> ACTUAL SIGNATURE <u>A. Calais</u> M.D. <u>Balto., Md</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville, Md.</u>				24a. RECEIVED BY REGISTRAR DATE <u>JAN 30 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

426 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middlesex</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middlesex</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>475 Torner Rd.</b>		d. STREET ADDRESS <b>475 Torner Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>E.</b> Last <b>VARINA, Sr.</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>28</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1887</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Condon E. Varina</b>		14. MOTHER'S MAIDEN NAME <b>Martha R. Buckey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. James E. Varina, Jr. - 4418 Marble Hall Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Hemiplegia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-renal Vascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>10 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 24</b> , 19 <b>58</b> , to <b>Jan 28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan 27</b> , 19 <b>58</b> , and that death occurred at <b>9 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George E. Shannon</b>		ADDRESS (Street, city or town, state) <b>820 Medical Arts Bldg.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>George E. Shannon, M. D.</b>		<b>Baltimore 1, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/31/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. J. Lickner &amp; Sons - Balto.</b>		24a. REC'D BY REGISTRAR <b>JAN 29 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. L. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Form No. 10

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>		<p>3. AGE [Illegible]</p>	
<p>4. DATE OF DEATH [Illegible]</p>		<p>5. TIME OF DEATH [Illegible]</p>		<p>6. PLACE OF DEATH [Illegible]</p>	
<p>7. CAUSE OF DEATH [Illegible]</p>		<p>8. MANNER OF DEATH [Illegible]</p>		<p>9. PLACE OF BIRTH [Illegible]</p>	
<p>10. OCCUPATION [Illegible]</p>		<p>11. MARITAL STATUS [Illegible]</p>		<p>12. EDUCATION [Illegible]</p>	
<p>13. SIGNATURE OF DECEASED [Illegible]</p>		<p>14. SIGNATURE OF WITNESS [Illegible]</p>		<p>15. SIGNATURE OF DECEASED [Illegible]</p>	
<p>16. SIGNATURE OF WITNESS [Illegible]</p>		<p>17. SIGNATURE OF DECEASED [Illegible]</p>		<p>18. SIGNATURE OF WITNESS [Illegible]</p>	
<p>19. SIGNATURE OF DECEASED [Illegible]</p>		<p>20. SIGNATURE OF WITNESS [Illegible]</p>		<p>21. SIGNATURE OF DECEASED [Illegible]</p>	
<p>22. SIGNATURE OF WITNESS [Illegible]</p>		<p>23. SIGNATURE OF DECEASED [Illegible]</p>		<p>24. SIGNATURE OF WITNESS [Illegible]</p>	
<p>25. SIGNATURE OF DECEASED [Illegible]</p>		<p>26. SIGNATURE OF WITNESS [Illegible]</p>		<p>27. SIGNATURE OF DECEASED [Illegible]</p>	
<p>28. SIGNATURE OF WITNESS [Illegible]</p>		<p>29. SIGNATURE OF DECEASED [Illegible]</p>		<p>30. SIGNATURE OF WITNESS [Illegible]</p>	
<p>31. SIGNATURE OF DECEASED [Illegible]</p>		<p>32. SIGNATURE OF WITNESS [Illegible]</p>		<p>33. SIGNATURE OF DECEASED [Illegible]</p>	
<p>34. SIGNATURE OF WITNESS [Illegible]</p>		<p>35. SIGNATURE OF DECEASED [Illegible]</p>		<p>36. SIGNATURE OF WITNESS [Illegible]</p>	
<p>37. SIGNATURE OF DECEASED [Illegible]</p>		<p>38. SIGNATURE OF WITNESS [Illegible]</p>		<p>39. SIGNATURE OF DECEASED [Illegible]</p>	
<p>40. SIGNATURE OF WITNESS [Illegible]</p>		<p>41. SIGNATURE OF DECEASED [Illegible]</p>		<p>42. SIGNATURE OF WITNESS [Illegible]</p>	
<p>43. SIGNATURE OF DECEASED [Illegible]</p>		<p>44. SIGNATURE OF WITNESS [Illegible]</p>		<p>45. SIGNATURE OF DECEASED [Illegible]</p>	
<p>46. SIGNATURE OF WITNESS [Illegible]</p>		<p>47. SIGNATURE OF DECEASED [Illegible]</p>		<p>48. SIGNATURE OF WITNESS [Illegible]</p>	
<p>49. SIGNATURE OF DECEASED [Illegible]</p>		<p>50. SIGNATURE OF WITNESS [Illegible]</p>		<p>51. SIGNATURE OF DECEASED [Illegible]</p>	
<p>52. SIGNATURE OF WITNESS [Illegible]</p>		<p>53. SIGNATURE OF DECEASED [Illegible]</p>		<p>54. SIGNATURE OF WITNESS [Illegible]</p>	
<p>55. SIGNATURE OF DECEASED [Illegible]</p>		<p>56. SIGNATURE OF WITNESS [Illegible]</p>		<p>57. SIGNATURE OF DECEASED [Illegible]</p>	
<p>58. SIGNATURE OF WITNESS [Illegible]</p>		<p>59. SIGNATURE OF DECEASED [Illegible]</p>		<p>60. SIGNATURE OF WITNESS [Illegible]</p>	
<p>61. SIGNATURE OF DECEASED [Illegible]</p>		<p>62. SIGNATURE OF WITNESS [Illegible]</p>		<p>63. SIGNATURE OF DECEASED [Illegible]</p>	
<p>64. SIGNATURE OF WITNESS [Illegible]</p>		<p>65. SIGNATURE OF DECEASED [Illegible]</p>		<p>66. SIGNATURE OF WITNESS [Illegible]</p>	
<p>67. SIGNATURE OF DECEASED [Illegible]</p>		<p>68. SIGNATURE OF WITNESS [Illegible]</p>		<p>69. SIGNATURE OF DECEASED [Illegible]</p>	
<p>70. SIGNATURE OF WITNESS [Illegible]</p>		<p>71. SIGNATURE OF DECEASED [Illegible]</p>		<p>72. SIGNATURE OF WITNESS [Illegible]</p>	
<p>73. SIGNATURE OF DECEASED [Illegible]</p>		<p>74. SIGNATURE OF WITNESS [Illegible]</p>		<p>75. SIGNATURE OF DECEASED [Illegible]</p>	
<p>76. SIGNATURE OF WITNESS [Illegible]</p>		<p>77. SIGNATURE OF DECEASED [Illegible]</p>		<p>78. SIGNATURE OF WITNESS [Illegible]</p>	
<p>79. SIGNATURE OF DECEASED [Illegible]</p>		<p>80. SIGNATURE OF WITNESS [Illegible]</p>		<p>81. SIGNATURE OF DECEASED [Illegible]</p>	
<p>82. SIGNATURE OF WITNESS [Illegible]</p>		<p>83. SIGNATURE OF DECEASED [Illegible]</p>		<p>84. SIGNATURE OF WITNESS [Illegible]</p>	
<p>85. SIGNATURE OF DECEASED [Illegible]</p>		<p>86. SIGNATURE OF WITNESS [Illegible]</p>		<p>87. SIGNATURE OF DECEASED [Illegible]</p>	
<p>88. SIGNATURE OF WITNESS [Illegible]</p>		<p>89. SIGNATURE OF DECEASED [Illegible]</p>		<p>90. SIGNATURE OF WITNESS [Illegible]</p>	
<p>91. SIGNATURE OF DECEASED [Illegible]</p>		<p>92. SIGNATURE OF WITNESS [Illegible]</p>		<p>93. SIGNATURE OF DECEASED [Illegible]</p>	
<p>94. SIGNATURE OF WITNESS [Illegible]</p>		<p>95. SIGNATURE OF DECEASED [Illegible]</p>		<p>96. SIGNATURE OF WITNESS [Illegible]</p>	
<p>97. SIGNATURE OF DECEASED [Illegible]</p>		<p>98. SIGNATURE OF WITNESS [Illegible]</p>		<p>99. SIGNATURE OF DECEASED [Illegible]</p>	
<p>100. SIGNATURE OF WITNESS [Illegible]</p>		<p>101. SIGNATURE OF DECEASED [Illegible]</p>		<p>102. SIGNATURE OF WITNESS [Illegible]</p>	

BUREAU V. S.

JAN 30 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

427

## CERTIFICATE OF DEATH

00423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3021 California Ave.</i>		d. STREET ADDRESS <i>3021 California Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Erminia</i> First Middle Last <i>Vicarini</i>		4. DATE OF DEATH Month <i>January</i> Day <i>18</i> Year <i>1958</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 30, 1869</i>
9. AGE (In years lost birthday) <i>88</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Louis Sprafico</i>		14. MOTHER'S MAIDEN NAME <i>Marianna</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Valentine Cioeff</i> Address <i>3021 California</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic C.V. Disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan. 5, 1957</i> , to <i>Jan. 18, 1958</i> , that I last saw the deceased alive on <i>Jan. 17, 1958</i> , and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Nathan Janney</i>		DATE SIGNED <i>1/18/58</i>	
PHYSICIAN'S NAME (Type) <i>Nathan Janney</i>		ADDRESS (Street, city or town, state) <i>7101 Harford Road #14 Baltimore, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/20/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>Jan 20 1958</i> 24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>	

BUREAU V. S.

JAN 20 1953

RECEIVED



428

CERTIFICATE OF DEATH

00424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>14 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>---</b> Last <b>VIVIRITO</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 4, 1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dealer- unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Groceries</b>	
11. BIRTHPLACE (State or foreign country) <b>Sealy, Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>August Vivirito</b>		14. MOTHER'S MAIDEN NAME <b>Rose Barrene</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospita. 1, Ft. Howard, Maryland</b>		Address <b>---</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SARCOMA, LEFT BUTTOCK</b> <b>191.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>---</b> DUE TO (c) <b>---</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation Left Hemipelvectomy - 4/1/57</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>---</b> p. m. <b>---</b> 19 <b>58</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 26 1957</b> , to <b>January 9 1958</b> , and that death occurred at <b>3:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>1/10/58</b> ACTUAL SIGNATURE <b>Irving Freeman</b> M.D. <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-14-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b> ADDRESS <b>6009 Harford Rd. Balto. 14, Md</b>		24a. REC'D BY REGISTRAR <b>JAN 14 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Wm. Seach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1885	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD.		JAN 14 1935		10:30 AM		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
LABORER		8 YEARS		METHODIST		MARRIED		15 YEARS	
PREVIOUS ILLNESS		DATE OF LAST ILLNESS		DATE OF LAST PHYSICIAN'S VISIT		NAME OF PHYSICIAN		HOSPITAL	
NONE		JAN 10 1935		JAN 12 1935		DR. J. H. HARRIS		BALTIMORE HOSPITAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

JAN 14 1935

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00425

429

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>182 Winters Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dora</b> Middle <b>H.</b> Last <b>Wade</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 13, 1915</b>	
9. AGE (In years last birthday) yrs. <b>42</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>58</b>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George C. King</b>				14. MOTHER'S MAIDEN NAME <b>Clara Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>[If yes, give war or dates of service]</b>		17. INFORMANT <b>James Wade</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cor pulmonale</b> <b>241X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchial asthma.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/1</b> , 19 <b>57</b> , to <b>1/4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1/4</b> , 19 <b>58</b> , and that death occurred at <b>2:00</b> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Morton M. Krieger</b>				DATE SIGNED <b>2:00</b> ADDRESS (Street, city or town, state) <b>2208 Euton Place</b>			
PHYSICIAN'S NAME (Type) <b>MORTON M. KRIEGER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 8, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ELROY C. WILSON FUNERAL HOME</b>				ADDRESS <b>1000 Brantley Avenue</b>		24a. REC'D BY REGISTRAR <b>JAN 10 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00426

430

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in The Pines 16 Eusting Ave</b>				d. STREET ADDRESS <b>3000 Reisterstown Rd</b>			
3. NAME OF DECEASED (Type or print) <b>Fred</b> First <b>G</b> Middle <b>Wallenstein</b> Last				4. DATE OF DEATH <b>Jan 9 1958</b> Month <b>9</b> Day <b>9</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 15, 1868</b>		9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR <b>9</b> Months <b>25</b> Days <b>25</b> Hours <b>25</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Collection Agency</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Solomon Wallenstein</b>				14. MOTHER'S MAIDEN NAME <b>Dina Rickenberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-0956</b>		17. INFORMANT <b>Miss Willma Wallenstein</b>		Address <b>Druid Pk Apt-A-3000 Reisterstown Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Discompensation</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Hypertension Cardiovascular Renal Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>27 mt.</b> <b>15 yr. 9</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-10-1956</b> , to <b>1-9-1958</b> , that I last saw the deceased alive on <b>1-8-1958</b> , and that death occurred at <b>5:50 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>				ADDRESS (Street, city or town, state) <b>6209 Frederick Ave. Baltimore 28, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>				DATE SIGNED <b>1-10-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-12-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Hebrew Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>David R. Martin</b>				24a. REC'D BY REGISTRAR <b>David R. Martin</b>		24b. REGISTRAR'S SIGNATURE <b>David R. Martin</b>	
David R. Martin, 1902 Rutaw Place				DATE <b>JAN 13 '58</b>			



BUREAU V. S.

1 JAN 13 1953

RECEIVED



216

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Lansdowne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>161 Howard St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph L.</u> Middle <u>Walsh</u> Last <u></u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1918</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>York, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Walsh</u>		14. MOTHER'S MAIDEN NAME <u>Mary Altoft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>216-05-4483</u>	
17. INFORMANT <u>Mrs. Laverne Walsh</u>		Address <u>161 Howard St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>28 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 27, 1955</u> to <u>Jan 5, 1958</u> , that I last saw the deceased alive on <u>Jan 5, 1958</u> , and that death occurred at <u>8:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Arthur Rossberg M.D.</u>		ADDRESS (Street, City or town, State) <u>2436 Washington Blvd, Balto 30 Md.</u>	
PHYSICIAN'S NAME (Type) <u>C. ARTHUR ROSSBERG M.D.</u>		DATE SIGNED <u>1/7/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 9, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jhn. T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
CERTIFICATE OF DEATH

WILLIAM  
BROWN

BUREAU V. S.

JAN 9 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, Film 224, 1-24-58 et

431

CERTIFICATE OF DEATH

00428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Owings Mills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>121 S. Ritters Lane</b>		d. STREET ADDRESS <b>121 S. Ritters Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Marguerite</b> Last <b>Warren</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>10</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1888</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR: Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George W. Bowen</b> <b>William M. Warren</b>		14. MOTHER'S MAIDEN NAME <b>Mary Geneva Scheiblein</b> <b>Mary/Geneva/Bowen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Albert W. Fowble, Owings Mills, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized oedema</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cirrhosis of liver with Portal Hypertension</b> DUE TO (c) <b>10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>Nov. 21</b> , 19 <b>47</b> , to <b>Jan. 10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan. 9</b> , 19 <b>58</b> , and that death occurred at <b>6:30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Rd. Reisterstown, Md.</b> DATE SIGNED <b>1-11-58</b>			
ACTUAL SIGNATURE <b>D. D. Coples</b>		M.D. <b>6 Hanover Rd. Reisterstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Coples, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 13/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Owings Mills, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons, Reisterstown, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JAN 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albert W. Fowble</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN		MEMPHIS, TENN		MEMPHIS, TENN		MEMPHIS, TENN	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		TIME OF DEATH	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		SUICIDE		ONE WEEK		JAN 6, 1968		10:00 AM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 13 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00429

432 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>18 hrs</b>				d. STREET ADDRESS <b>3219 Presstman Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROGER</b> Middle <b>C</b> Last <b>WARRENBERGER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/13/90</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>58</b>		IF UNDER 24 HRS. Months <b>10</b> Days <b>19</b> Hours <b>58</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Agent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>421.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CALCIFIC AORTIC STENOSIS</b> DUE TO (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>January 9 10:50 PM</b> 19 <b>58</b> , to <b>January 10 4:50 PM</b> 19 <b>58</b> , and that death occurred at <b>4:50 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b> DATE SIGNED <b>1/11/58</b>							
ACTUAL SIGNATURE <b>Donald D. Mark</b>				M.D. <b>Fort Howard, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-15-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Jr.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>JAN 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
 2. SEX: [illegible]  
 3. AGE: [illegible]  
 4. DATE OF BIRTH: [illegible]  
 5. PLACE OF BIRTH: [illegible]  
 6. OCCUPATION: [illegible]  
 7. CAUSE OF DEATH: [illegible]  
 8. DATE OF DEATH: [illegible]  
 9. PLACE OF DEATH: [illegible]  
 10. SIGNATURE OF PHYSICIAN: [illegible]  
 11. SIGNATURE OF REGISTRAR: [illegible]  
 12. SIGNATURE OF WITNESS: [illegible]

BUREAU V. S.

JAN 14 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 433

## CERTIFICATE OF DEATH

### 00430

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mths4dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lura</b> <b>May</b> <b>Whalen</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Harry</b>		14. MOTHER'S MAIDEN NAME <b>Susan Barnes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-18-8992</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 13, 1958</b> , to <b>Jan. 24, 1958</b> , that I last saw the deceased alive on <b>Jan. 24, 1958</b> , and that death occurred at <b>11:15a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>1-24-58</b>			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 27, 58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>DeerPark Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

MODE OF DEATH

PERIOD OF ILLNESS

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REMARKS

SIGNATURE

DATE

PLACE

REMARKS

SIGNATURE

DATE

PLACE

REMARKS

SIGNATURE

DATE

PLACE

REMARKS

SIGNATURE

DATE

PLACE

REMARKS

SIGNATURE

DATE

PLACE

REMARKS

BUREAU V. S.

JAN 30 1938

RECEIVED

434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>6yr2mths20dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>16x-2</b>			
3. NAME OF DECEASED (Type or print) First <b>Ellsworth</b> Middle <b>Wheeler</b> Last <b>Chapelgate Lane</b>				4. DATE OF DEATH Month <b>1</b> Day <b>11</b> Year <b>1958</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1884</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joshua Wheeler</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Tipton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>493X</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 20</b> , 19 <b>57</b> , to <b>1-11-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-11-</b> , 19 <b>58</b> , and that death occurred at <b>6</b> <sup>10</sup> <b>A.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>1-11-58</b>			
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>				<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Jan 14 1958</b>		<b>St. Hill Cemetery Laurel Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. D. McDonald</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BUREAU ONE 19

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BUREAU V. S.

JAN 14 1958

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

435

CERTIFICATE OF DEATH

Reg. Dist. No. 00432

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9606 Harford Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Heber</u> Middle <u>Glenn</u> Last <u>Whitehead</u>		4. DATE OF DEATH Month <u>January</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Electric Co.</u>	9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonidus Whitehead</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Balkum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Spanish Amer.</u>		16. SOCIAL SECURITY NO. <u>215-09-9191A</u>	
17. INFORMANT <u>Mrs. Nora D. Whitehead</u>		Address <u>9606 Harford Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma prostate &amp; bladder</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Buerger's Disease, amputation left leg 1949</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. p.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>1948</u> to <u>Jan. 5, 1958</u> , that I last saw the deceased alive on <u>Jan. 3, 1958</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11758 Taylor Ave. Balto. Md.</u> DATE SIGNED <u>1-14-58</u>			
ACTUAL SIGNATURE <u>A.M. Bacon</u>		M.D. <u>2810 Taylor Ave. Balto. Md.</u>	
PHYSICIAN'S NAME (Type) <u>A.M. BACON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 8, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carney Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	24a. REC'D BY REGISTRAR <u>W. H. H. H.</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>

BUREAU V. S.

1958 6 JAN

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00433

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2320 Ruth Ave.</b>		d. STREET ADDRESS <b>2320 Ruth Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>J.</b> Last <b>Wisniewski</b>		4. DATE OF DEATH Month <b>1</b> Day <b>22</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 - 3 - 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis Wisniewski</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Wisniewski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mary Wisniewski - 2320 Ruth Ave. #19</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>JACK COLLINS</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JACK COLLINS</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>1-22-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-25-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Dabrowski - 10014 Dundalk Ave</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>JAN 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Dabrowski</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH-CERTIFICATE OF DEATH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. R.

JAN 24 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

437

## CERTIFICATE OF DEATH

00434

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Fla.</b> b. COUNTY <b>Coral Gables</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>48X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>May Pullen Convalescent Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARGARET C. WITTE</b>		4. DATE OF DEATH <b>Jan 19 1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 29, 1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Valentine Hohlweg</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Knerim</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Mildred Witte Struven-1110 Sevilla Ave.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest, arteriosclerotic heart Dis.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic generalized, osteoporosis</b> DUE TO (c) <b>Cerebral Sclerosis -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Dec 57 to Jan 58</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 Jan 1958</b> to <b>19 Jan 1958</b> , that I last saw the deceased alive on <b>19 Jan 1958</b> , and that death occurred at <b>11:55 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard E. Hall</b> M.D.		ADDRESS (Street, city or town, state) <b>Sykesville, Md</b> DATE SIGNED <b>19 Jan 58</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/22/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. J. Lickner &amp; Sons - Baltore</b>		24a. REC'D BY REGISTRAR <b>Jan 20 '58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 sl. 422 be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 to 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 21 1958

RECEIVED

438

## CERTIFICATE OF DEATH

00435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>ARABUTAS</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE - ARABUTAS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>903 LEEDS AVE</u>				d. STREET ADDRESS <u>903 LEEDS AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA D. E. YOUNG</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 10 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DECEMBER 10/1906</u> 51 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INTERIOR DECORATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEW YORK OUTLET</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE - MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH. DUBALSKY</u>				14. MOTHER'S MAIDEN NAME <u>EVA -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-09-6677</u>			
17. INFORMANT <u>William Young</u>				Address <u>903 LEEDS AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SARCOMA, UTERUS WITH</u> <u>174X</u> DUE TO <u>GENERALIZED</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTASES</u> DUE TO (c) <u>1 YEAR</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-18</u> , 19 <u>57</u> , to <u>JAN. 10</u> , 19 <u>58</u> that I last saw the deceased alive on <u>JAN. 9</u> , 19 <u>58</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Schaefer</u>				ADDRESS (Street, city or town, state) <u>401 RANDOM ROAD</u>			
PHYSICIAN'S NAME (Type) <u>JOHN F. SCHAEFER</u>				DATE SIGNED <u>1-11-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOST HOLY REDEEMER</u>		22d. LOCATION (City, town, or county) (State) <u>BE LAIR RD. MARYLAND.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James W. Adair</u>				ADDRESS <u>637 W. 1st St.</u>		24a. REC'D BY REGISTRAR <u>JAN 13 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





439

CERTIFICATE OF DEATH

00436

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Howard</b>				c. LENGTH OF STAY IN 1b <b>54 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>I.</b> Last <b>YOUNG</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/11/96</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Medical Arts Bldg.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Edward Young</b>				14. MOTHER'S MAIDEN NAME <b>Mary Lou Cross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>				16. SOCIAL SECURITY NO. <b>220-97-4662</b>		17. INFORMANT <b>Clin.Rec.Vets.Admin.Hospital, Ft.Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE WITH CONGESTIVE FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>UNKNOWN</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BENIGN PROSTATIC HYPERTROPHY</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>November 11, 19 57</b> , to <b>January 4, 19 58</b> , and that death occurred at <b>12:02 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Md.</b> DATE SIGNED <b>1/4/58</b>							
ACTUAL SIGNATURE <b>G. D. KINGTON, M. D.</b>				PHYSICIAN'S NAME (Type) <b>G. D. KINGTON, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-8-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. Smith</b>	

CERTIFICATE OF DEATH

439

NAME OF DECEASED JAMES H. HARRIS		AGE 65	
SEX Male		RACE White	
DATE OF DEATH Jan 2, 1938		PLACE OF DEATH Home	
CITY Baltimore		COUNTY Baltimore	
STATE Maryland		COUNTRY United States	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several weeks	
TREATMENT Medical		HOSPITAL None	
BURIAL Buried		CITY Baltimore	
COUNTRY United States		STATE Maryland	

NAME OF DECEASED JAMES H. HARRIS		AGE 65	
SEX Male		RACE White	
DATE OF DEATH Jan 2, 1938		PLACE OF DEATH Home	
CITY Baltimore		COUNTY Baltimore	
STATE Maryland		COUNTRY United States	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several weeks	
TREATMENT Medical		HOSPITAL None	
BURIAL Buried		CITY Baltimore	
COUNTRY United States		STATE Maryland	

BUREAU V. 3

JAN 7 1938

RECEIVED

440

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sister Mary Wuna Zahm</u> Middle <u></u> Last <u></u>				4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1871</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Warsaw, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter</u>				14. MOTHER'S MAIDEN NAME <u>Teresa Neunder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Sister M. Peter Fourier</u>		Address <u>Notch Cliff, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. of breast</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>Jan. 26</u> , 19 <u>55</u> , to <u>Jan. 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 21</u> , 19 <u>58</u> , and that death occurred at <u>2</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7501 York Road Towson 4, Md.</u> DATE SIGNED <u>Jan. 21, 1958</u>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 1-27-58</u>		22b. DATE THEREOF <u>1-27-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NR TOWSON, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles F. O'Donnell</u>		ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DAY OF

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	

441

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Brinkham Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Zielinski</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-1895</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Klima</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>George Zielinski</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO (b) <b>Aortic Stenosis</b> DUE TO (c) <b>Rheumatic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Instantaneous</b> <b>40 years</b> <b>40 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Auricular fibrillation</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 12</b> , 19 <b>45</b> , to <b>Oct 29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 3</b> , 19 <b>57</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harvey L. Fuller</b> M.D.		ADDRESS (Street, city or town, state) <b>Ridge Rd. Baltimore 6, Md.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>HARVEY L. FULLER, M.D.</b>		<b>1/23/58</b> <b>Murdock 7-4400</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/25/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. 21. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Bruzdinski</b> ADDRESS <b>1407 Eastern Ave.</b>		24a. REC'D BY REGISTRAR <b>JAN 27 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Deh...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 27 1953

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										00439
Item 18 Film 225 2-10-58 ams										
442										
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 20</u>			c. LENGTH OF STAY IN 1b <u>4 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Baltimore 20</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 Cockpit Street</u>					d. STREET ADDRESS <u>1 10 Cockpit St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Shepherd Ziler</u>					4. DATE OF DEATH Month Day Year <u>JAN 28 1958</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 29, 1875</u>		9. AGE (In years last birthday) <u>82 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>30</u>	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAR REPAIRMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Washington Ziler</u>					14. MOTHER'S MAIDEN NAME <u>MARTHA ELIZABETH HANSROTE</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>705-09-9690</u>		17. INFORMANT Address <u>Daughter - Dorothy Ruble 10 Cockpit St.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u>A S C V D</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-28</u> , 19 <u>58</u> , to <u>1-28</u> , 19 <u>58</u> that I last saw the deceased alive on <u>1-28</u> , 19 <u>58</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>805 Fusco Ave</u> <u>11-28-58</u> ACTUAL SIGNATURE <u>Marvin Bombr</u> M.D. PHYSICIAN'S NAME (Type) <u>MARVIN. BOMBRO</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Mausoleum</u>			22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Hafer</u>					24a. REC'D BY REGISTRAR <u>Cumberland Md.</u>		24b. REGISTRAR'S SIGNATURE <u>1958</u>			

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		JAN 15 1880		NEW YORK	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JUN 10 1910		NEW YORK		MARY J. JONES		FEB 10 1930		NEW YORK	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SPECIAL INSTRUCTIONS	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		CATHOLIC			
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF SPOUSE		SIGNATURE OF CHILD	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
FEB 10 1930		FEB 10 1930		FEB 10 1930		FEB 10 1930		FEB 10 1930		FEB 10 1930	

BUREAU V. 1

FEB 8 1930

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